



Advancing Health Communication

*The PCS Experience
in the Field*

Phyllis Tilson Piotrow
Jose G. Rimon II
Alice Payne Merritt
Gary Saffitz

POPULATION COMMUNICATION SERVICES



Advancing Health Communication

The PCS Experience in the Field

Phyllis Tilson Piotrow
Jose G. Rimon II
Alice Payne Merritt
Gary Saffitz

Johns Hopkins Bloomberg School of Public Health
Center for Communication Programs

March 2003

Suggested Citation:

Piotrow, P. T., Rimon, J.G. II, Payne Merritt, A., & Saffitz, G. (2003). *Advancing Health Communication: The PCS Experience in the Field*. Center Publication 103. Baltimore: Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs.

This publication may be reproduced without permission provided the material is distributed free of charge and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs is acknowledged. Opinions expressed in this report are those of the authors and do not necessarily reflect the views of sponsoring agencies.

Edited and produced by Center Publications:

Kim S. Martin, Editor

Rita C. Meyer, Materials Development Manager

Photo Credits:

Bangladesh Center for Communication Programs, cover front, pages 21 and 67;
CCP, pages 10, 20; 25, 35, 37, 42, 43, 44, 49, 58, 63, 69, 70;
Maria Pia Valdivia, CCP, page i and 30 (both);
Caroline Jacoby, page 9;
Young Mi Kim, CCP, pages 23 and 32;
Elizabeth Serlemitsos, page 39;
William Mackie, CCP, page 47;
Nrityanjali Academy, page 53;
Njamburi/Cabak ELS, page 61.



Prepared by the Johns Hopkins Bloomberg School of Public Health / Center for Communication Programs with support from the United States Agency for International Development under the Population Communication Services project CCP-A-00-96-90001-00



CONTENTS

Preface & Acknowledgments	v
Introduction	1
Overarching Conclusions	5
The 52 Lessons	6
Chapter One	Learn About Local Needs 9
Chapter Two	Mobilize Your Team With a Clear Strategy 13
Chapter Three	Address Key Program Issues 23
	DECENTRALIZATION 24
	INTEGRATION OF SERVICES 26
	QUALITY OF CARE 29
	GENDER 34
Chapter Four	Stimulate Community Participation 39
Chapter Five	Deal with Controversy 47
Chapter Six	Measure How the Program Worked 53
Chapter Seven	Share Results and Credit 61
Chapter Eight	Build Capacity and Sustainability 67
Conclusion	73
Map of PCS Countries	74
PCS Awards	75
References	76
Publications & Reports	Produced Under PCS 81
Staff Acknowledgments	89

PREFACE & ACKNOWLEDGMENTS

How can we recognize and thank all of the people—hundreds, perhaps even thousands—whose work made the Population Communication Services project (PCS) possible over the last 20 years? And especially how can we acknowledge the insights gained by the last phase of the project (PCS4) from so many colleagues and supporters?

First, we want to thank the staff of the U.S. Agency for International Development (USAID) whose vision and understanding created an ambitious communication project designed to change knowledge, attitudes, and behavior in reproductive health. The Center for Population, Health and Nutrition, the Office of Population, and its Communication, Management and Training Division brought the PCS project to fruition and guided it for 20 years. USAID Missions around the world, following the insightful guidance of experienced and qualified Health/Population/Nutrition officers, provided most of the funding to carry out this work. And together USAID staff worldwide provided the impetus and encouragement to experiment with new approaches in communication and allowed PCS staff the flexibility to innovate, take prudent risks, and explore new ground expanding the frontiers of knowledge and practice in health communication.

We thank all of our counterparts and collaborators around the world who actually carried out the programs from which we all have learned so much together. PCS was pleased to provide funding, strategic guidance, individual training/mentoring, and institutional capacity building, but the real credit for the results and lessons learned belongs to our partners in-country who work with these programs day in and day out. Whether government agencies or nongovernment and community-based organizations, professional associations, universities or commercial firms, they actually carried out the work described herein.

We thank all of the staff and employees of the Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP) who worked on the project and all the partner organizations within the PCS4 project – The Academy for Educational Development, Save the Children, the Centre for Development and Population Activities, and Prospect Associates/American Institutes of Research, and of course the Johns Hopkins Bloomberg School of Public Health. At every level, they supported PCS and helped us all solve the problems described here and benefit from the lessons learned.

Finally, we thank our professional colleagues and co-workers in the field of public health including other USAID cooperating agencies and counterparts in the United Nations agencies whose understanding of reproductive health issues and whose dedication to strategic communication and informed choice have been a constant source of strength and encouragement.

We hope that this summary of the lessons learned from the PCS project can serve as a practical guide to all. We hope it will be a useful problem-solving tool that can be further refined and improved to resolve the challenges that face all those working in the exciting field of health communication in the 21st century.

Jane T. Bertrand, PhD, MBA

Professor, Bloomberg School of Public Health

Director, Center for Communication Programs

March 2003

INTRODUCTION

Why don't people pay more attention to their health? Why don't people who have a choice make healthier choices about personal, family, and sexual behavior? Why don't people make better use of existing health facilities? And, above all, what can public health practitioners and communication experts do to help people make healthier choices? How can public health practitioners work to improve the environment in which people make their choices? New answers and approaches emerged in the last two decades that can help address and resolve some of these problems.

This guide for health communication programs is based on the worldwide experience of the Population Communication Services (PCS4) project from 1995-2002. Led by the Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP), PCS4 was supported by the U.S. Agency for International Development (USAID). U.S. partners in PCS4 included the Academy for Educational Development (AED), Save the Children, the Centre for Development and Population Activities (CEDPA) and Prospect Associates/American Institutes for Research. Building on 20 years of experience that began with the first PCS project in 1982, PCS4 offers here some practical lessons as to what works, what works better, and what does not work in the rapidly evolving and advancing field of health communication.

Health communication has changed dramatically over the last half century, passing through at least four different periods:

The clinic era, based on a medical care model and the notion that if people knew where services were located they would find their way to the clinics. “Build it and they will come” was the underlying theme (Rogers, 1973).

The field era, a more active approach emphasizing outreach workers, community-based distribution, and a variety of information,

education, and communication (IEC) products. These included posters, leaflets, radio broadcasts, and mobile units (Rogers, 1973).

The social marketing era, developed from the commercial concept that consumers will buy the products they want at subsidized prices. Highly promoted brands stimulated the demand side while convenient access through local shops and pharmacies expanded the supply side (Andreasen, 1995; Rimon, 2001).

And today, **the era of strategic behavior change communication**, founded on behavioral science models for individuals, communities, and organizations that emphasize the need to influence social norms and policy environments so as to facilitate and empower the iterative and dynamic process of both individual and social change (Figueroa et al., 2002; Piotrow & Kincaid 2001).

As a result, the field of health communication has evolved and expanded greatly. From being initially a matter of high volume production of simple print material – posters and brochures for clinics – communication has become a vital strategic component of health programs. No longer simply repeating untested slogans like “A small family is a happy family” or providing pictorial instruction on why and how to use specific contraceptive methods, communication is now a vital and indispensable guide for many interventions. It represents not only the most conspicuous part of most preventive health programs but also the strategic themes to enhance the importance of health programs for policymakers and the public alike. Today, strategic communication can serve not only to increase the demand for specific preventive health services but also to motivate the suppliers of health services – providers at all levels – toward their commitment to serve their clients.

Many factors contributed to this growing emphasis on communication, including:

- Growing evidence that well-designed communication interventions can have an impact on health behaviors and practices, not just knowledge and attitudes;
- A substantial expansion of mass media, new information technologies, and especially television to reach large audiences worldwide;

- The decentralization of health services, giving more power to local governments;
- Increased attention to the role of women, and other gender concerns;
- Emphasis on better quality, client-centered health care services, including counseling and client-provider communication;
- The spread of HIV/AIDS and growing recognition that child health and control of many emerging diseases may depend as much on individual and community behavior as on medical technology; and
- The continuing search for behavior change models that take account of complex interactions involving individual behavior, community norms, and social/structural change.

Many organizations and programs contributed to this transformation:

- The International Planned Parenthood Federation and its member associations, which were the first to take on information, education, and communication (IEC) and advocacy for family planning programs;
- PATH, which pioneered the development and pretesting of illustrated materials for low-literate populations;
- The Academy for Education Development, which applied systematic approaches and tools to IEC for child survival and related interventions;
- Manoff Associates and Porter Novelli International, which brought professional advertising approaches to bear on health promotion;
- Population Services International, DKT Foundation, and the Futures Group, which experimented with different forms of social marketing;
- EngenderHealth, which focused on interpersonal communication and counseling for informed choice;
- Save the Children and CARE, which incorporated strong community participation and mobilization into local programs;

- The Rockefeller Foundation, which emphasized the role of communication to facilitate broad social change; and above all,
- USAID, which took the initiative in funding major strategic communication initiatives, such as the PCS project.

Other institutions and donors also advanced important approaches and opportunities that raised the field of health communication to new importance.

From IEC (information, education and communication) to BCC (behavior change communication), from informed individual choice to social change and grassroots mobilization, from branding for ready recognition to empowering for personal and collective self-efficacy, from education to entertainment-education, from multimedia campaigns to strategic communication, health communication is a field on the move. Since 1982—and especially from 1995 to 2003—the PCS project played a significant role in that movement. PCS observed, implemented, learned, and documented many useful lessons and can serve other ongoing programs in the future.

This report covers this progression and its challenges in a narrative fashion, appropriate to the real-world challenges of implementing a health communication program in the field. It proposes feasible actions that over the years helped PCS resolve some of the problems facing health communication programs at different stages. It also addresses the new directions health communication has taken over the last two decades. This report is designed to help organizations carry out effective communication programs by addressing step-by-step some of the major problems likely to arise and by focusing on problem-solving in the rapidly changing field of health communication.



OVERARCHING CONCLUSIONS

Five overarching conclusions stand out after two decades of experience by numerous organizations in the United States and worldwide.

1. Health communication programs can be effective.

Multiple research reports and two authoritative meta-analyses of 48 US and 39 international programs indicate people often change their behavior as a result of strategic communication campaigns and programs. An effect or influence of 9-10 percentage points in the desired health behavior can occur as a result of large-scale communication campaigns (Snyder & Hamilton, 2002; Snyder et al., 2003; Hornik, 2002).

2. The larger the program reach, the greater the impact.

Comprehensive programs using mass media as well as community activities are more effective than small-scale efforts. While on an individual basis, one-to-one personal contact may be most persuasive, from a public health perspective, the reach (that is, the number of people exposed or involved) is a major determinant of success. Moreover, programs based on a coherent national strategy can go to scale to achieve national impact (Hornik, 2002; Piotrow et al., 1997; Snyder et al., 2003).

3. Entertainment-education is a powerful tool to reach large numbers of people and engage hard-to-reach audiences.

No one enjoys being lectured to but everyone enjoys and often learns from entertainment, whether broadcast through radio or television, or performed in person. Young people, men and women, at home and at work, rural families, and even busy health care providers can identify with actors as role models and understand the dramatic consequences of wise or foolish health behavior. They can also participate in music, dance, and sports events (Bouman, 1999, Cody et al., 2003, Galavotti et al., 2001; Singhal & Rogers, 1999; Storey & Jacobson 2002).

4. The more participatory the program, the more readily it can lead to sustained individual and social change.

When communities are engaged in designing, carrying out, and monitoring communication programs, they are more likely to change and to maintain those changes than when programs are designed or imposed by outsiders. Community action takes time to organize and needs continuing support, but the effects can be long lasting (Gumucio Dagron, 2001; Howard-Grabman & Snetro, 2003).

5. Every program has three main constituencies, each one of which must be satisfied.

These are 1) intended beneficiaries, audiences or participants, without whose behavior change no improvements will occur; 2) local team members and implementers, without whose skills and commitment, programs will not get off the ground; and 3) sponsors and donors, without whose support little can be accomplished. Continuity of support from all three elements is essential to an effective program.

THE 52 LESSONS

LEARN ABOUT LOCAL NEEDS

- 1 Know the country and its priority health issues before proposing action.
- 2 Propose specific activities that focus on priority local needs, address existing obstacles to success, and add value to ongoing policies and programs.
- 3 Explore small problems to identify larger needs.
- 4 Adapt experiences from other countries where appropriate.

MOBILIZE YOUR TEAM WITH A CLEAR STRATEGY

- 5 Choose host country partners strategically.
- 6 Form a technical communication task force including government and nongovernment experts to advise and assist.
- 7 Work together to develop an overall communication strategy and accomplish it.
- 8 Use a common set of practical tools and models so your entire team is speaking the same language and using the same “brand.”
- 9 Mentor team members to use the tools and models and train host-country trainers to train others in their use.
- 10 Include team members from different disciplines and create opportunities to work together.
- 11 Develop resource centers to share samples of relevant, well-designed materials from other programs.

ADDRESS KEY PROGRAM ISSUES

DECENTRALIZATION

- 12 Develop new tools and approaches for health advocacy at decentralized levels.

- 13 Station more field staff outside capital cities.
- 14 Develop communication skills at the community level and tailor information to local concerns.

INTEGRATION OF SERVICES

- 15 Adapt the same basic framework and process to develop communication programs for different or multiple health interventions.
- 16 Encourage providers and clients to ask questions and provide referrals on a range of health issues, not only the reason for a specific visit.

QUALITY OF CARE

- 17 Enlist support for quality of care at the highest possible level.
- 18 Build support for quality of care at the community level.
- 19 Use appropriate quality certification and marketing strategies nationally and locally.
- 20 Focus on communication skills as well as technical skills of providers to improve quality of care.
- 21 Plan Observation Study Workshops (OSWs) as a knowledge management tool to show quality of care proponents in one country how model programs work in other countries.

GENDER

- 22 Address a broad range of gender issues in developing health communication programs.
- 23 Seek out women to play an active part in implementing health communication programs.
- 24 Use mass media and entertainment-education to present new role models versus traditional stereotypes for both women and men.
- 25 Observe differences, if any, between treatment of men and women in family health clinics and organize appropriate provider and client training to address inequities.

FROM PCS

STIMULATE COMMUNITY PARTICIPATION

- 26** Work directly with communities to help them define their own needs and develop their own solutions.
- 27** Identify key groups or segments of the population and develop specific programs with them and for them.
- 28** Work with youth leaders and active youth organizations to develop programs.
- 29** Build coalitions to enlist broad and strong local participation.
- 30** Work with entertainers and celebrities to reach large numbers of people and engage hard-to-reach audiences.
- 31** Use appropriate new information technology to involve more people.

DEAL WITH CONTROVERSY

- 32** Pretest all materials and language and respond to participant concerns.
- 33** Establish and maintain good working relations with the media before controversy occurs.
- 34** Line up allies and experts to help make your case.
- 35** Manage controversy to present more evidence of the health and other benefits of your program but make small concessions if necessary.
- 36** Find evidence of public support to counteract critics.

MEASURE HOW THE PROGRAM WORKED

- 37** Plan for evaluation at the start of any intervention.
- 38** Use and clearly state a theoretical behavior change model to guide your program.
- 39** Use available external resources, especially Demographic and Health Surveys (DHS), which provide comparable cross-sectional data over many years.

- 40** Develop multiple research designs and data sources to reinforce your conclusions.
- 41** Recognize and control for confounding variables such as changes in policy, other programs or promotions, or selective individual exposure.
- 42** Combine qualitative and quantitative methods.
- 43** Design evaluations not only to measure impact but also to improve future programs.

SHARE RESULTS AND CREDIT

- 44** Keep donors, officials, program staff, and participants informed on a continuing basis of activities, research, and evaluation of results in brief, non-technical reports.
- 45** Schedule a press conference or briefing to provide a comprehensive overview of your project when evaluation results are available.
- 46** Prepare and distribute working papers, field reports, specialized newsletters, and summaries as well as peer-reviewed articles.
- 47** Do not claim more impact than you can demonstrate.
- 48** Use information technology to disseminate program results.

BUILD CAPACITY AND SUSTAINABILITY

- 49** Build or strengthen the capacity of institutions in-country to carry out health communication programs.
- 50** Support ongoing individual and institutional training programs with strong in-country units and access to high-level international training.
- 51** Generate funds directly for local projects or organizations as soon as possible.
- 52** Maintain close links with counterparts and partners even after formal relationships have ended.

Chapter One



LEARN ABOUT LOCAL NEEDS

- 1 Know the country and its priority health issues before proposing action.
- 2 Propose specific activities that focus on priority local needs, address existing obstacles to success, and add value to ongoing policies and programs.
- 3 Explore small problems to identify larger needs.
- 4 Adapt experiences from other countries where appropriate.

1 *Know the country and its priority health issues before proposing action.*

In-depth knowledge of a country and its health issues is a must before initiating a program. Sponsors and donors expect and respect knowledgeable experts when making program decisions. Developing a successful program requires considerable preliminary time and effort to talk to the populations at risk, to listen to their concerns, to understand the local situation, to identify key audiences for various messages, to recruit qualified local staff, and to segment the population to address special needs. This is particularly important now as programs become more and more decentralized. Whether in advance or as part of the analysis phase of project development, any organization planning a communication program first needs accurate knowledge of the people and the local issues before proposing materials or activities. “*Learn to listen, listen to learn*” is good advice when starting out.

You should allow sufficient time to review relevant research and documentation, and conduct additional research as needed. For example, in-depth analysis of Demographic and Health Survey (DHS) data was essential in designing strategies such as the *Las Manitos* campaign in Bolivia, which emphasized maternal and child health in order to position family planning services; the Red Line multi-year strategy in Nepal, which focused on women with an unmet need for family planning; HIV/AIDS campaigns in Ghana and Tanzania, which drew heavily on community action and resources; and support for the Healthy Indonesia 2010 coalition, which addressed broad health needs through coalitions of locally active organizations and active corporate participation. Each strategy was country-specific and based on an understanding of the needs and concerns in those countries.



PCS's Nepal Field Office planned a multi-year strategy that focused on women's unmet need for family planning.

2 *Propose specific activities that focus on priority local needs, address existing obstacles to success, and add value to ongoing policies and programs.*

Different countries have different communication problems and capabilities. In Nepal, for example, transportation problems not only prevented clients from visiting health centers but also made it hard for service providers to participate in essential training to improve client-provider interaction. The solution was the Radio Communication Project, a two-pronged radio distance learning approach with a serial drama for potential clients focusing on village life and health and a combined drama-learning program for service providers. These serials have been on the air for the last six years. Multiple surveys and evaluations show increased clinic attendance, improved client-provider communication, and increased contraceptive use as well as a new sense of supportive social norms (Boulay et al., 2002; Storey et al., 1999; Sood et al., 1998).

Based on audience research and local participation, the initiative fit well into existing Nepalese concerns over the unsympathetic way providers from higher social classes interacted with clients, especially those from a different cultural background. The Nepalese program also hoped to increase attendance for preventive services at under-utilized facilities. At the same time, it provided villagers with new information, such as the value of Vitamin A supplements, to help them improve family health.

3 *Explore small problems to identify larger needs.*

Sometimes solving relatively small specific problems may depend on larger changes or shifts in emphasis to a more comprehensive solution. In Egypt, for example, an invitation to prepare an inventory and assessment of print materials for low literate women paved the way to a much larger program. While preparing the inventory, PCS staff found that the problem was not the quality of print materials, but rather the quality of overall service, especially client-provider communication, lack of respectful treatment, and no personalized counseling. Their findings led to a new emphasis on the quality of care, by introducing family planning counseling into the country and

then strategically positioning a private sector agency, Clinical Services Improvement (CSI), as a provider with “distinguished service at an affordable price.” The Ministry of Health soon adopted and expanded this approach through its own quality recognition Gold Star program. From a small start, the Government of Egypt and USAID developed a comprehensive program, the Gold Star Initiative to maximize access and quality (MAQ). It became the world’s largest public sector quality improvement program and is now cited as a model for other countries. (El Shaffie et al., 1998).



Egypt’s Gold Star program recognized quality health facilities.

4 ***Adapt experiences from other countries where appropriate.***

Although each country is different, lessons learned in one situation may be adapted to meet similar needs elsewhere. It is not always necessary to start from scratch and reinvent the wheel. For example, PCS proposed an initiative in Jordan with religious leaders to pave the way for a national campaign of family life education for young people. This initiative, which began with a survey of religious leaders to document their basic support for family planning, benefited from the experience of previous programs with religious leaders in Egypt and Senegal (Underwood, 2000). In each country, this approach established the support of the Muslim religious community, which in turn made subsequent campaigns more acceptable and more effective. Elsewhere, the Brazil *PROQUALI* program and the Philippines *Sentrong Sigla* movement applied a strategic quality of care approach adapted from Egypt’s earlier Gold Star program and modified to meet specific Brazilian and Philippine priorities.

A warning, however. Some donors and decision-makers do not like to be inundated with stories about successes elsewhere. They may insist that “My country is different. That won’t work here.” Thus it is essential to be knowledgeable about the country and communities under consideration *before* offering ideas based on the experience of other countries. This is especially true in the field of health communication where the cultural context is important. By considering cultural context, you can avoid being accused of using a so-called “cookie-cutter” approach.

Chapter Two



MOBILIZE YOUR TEAM WITH A CLEAR STRATEGY

- 5 Choose host country partners strategically.
- 6 Form a technical communication task force including government and nongovernment experts to advise and assist.
- 7 Work together to develop an overall communication strategy and accomplish it.
- 8 Use a common set of practical tools and models so your entire team is speaking the same language and using the same “brand.”
- 9 Mentor team members to use the tools and models and train host-country trainers to train others in their use.
- 10 Include team members from different disciplines and create opportunities to work together.
- 11 Develop resource centers to share samples of relevant, well-designed materials from other programs.

5 Choose host country partners strategically.

One of the most important decisions to make in designing or implementing a program is the choice of partners. Identifying and empowering the lead partner is especially critical because this decision can determine both the direction of the work and its success or failure. Sometimes donors make the decision, sometimes the government. If possible, communication professionals should take advantage of the opportunity to weigh in on the best mix of partners and counterparts.

A useful tool to assess institutional capacity is informally known as the *6 Cs Approach*. It assesses:

1. **Competence** of an organization and its leadership to achieve results;
2. **Commitment** to the issue, whether family planning, HIV/AIDS, or other health interventions;
3. **Clout** (or influence) in reaching and persuading key decision-makers;
4. **Coverage** and cost-effectiveness in reaching intended populations;
5. **Continuity**, especially in terms of future sustainability; and
6. **Collaboration** with other local and international agencies.

On this basis, PCS chose the Turkish Foundation for Family Health and Planning (TFFHP) to work on the first-ever mass media campaign to promote family planning in the predominately Muslim country. It laid the groundwork for TFFHP's expansion into social marketing, clinic networks, and advocacy programs (Kincaid et al., 1992).

Elsewhere these criteria were applied to help decide whether to work with one or another government unit, with a family planning organization, or with various commercial firms. Subsequently they were spelled out in more detail with intermediate benchmarks for each criterion. This approach encouraged critical self-assessments by several counterpart organizations and helped them identify technical assistance needs.

6 *Form a technical communication task force including government and nongovernment experts to advise and assist.*

Bring all potential partners in a communication project together 1) to share information on activities underway and planned so as to avoid duplication, 2) to encourage members to identify different roles to avoid competition; and 3) to develop a common strategy and plan of action. PCS facilitated the formation of strategic communication task forces or committees in about 30 countries, many of which played a crucial role. In Bolivia, the subcommittee was originally for nongovernment organizations (NGOs), but it became so active that the Ministry of Health asked to lead it and became a committed and public partner in subsequent campaigns (Saba, 1997). In Bangladesh, a large communication task force with several subcommittees drafted the National Family Planning, Maternal Child Health IEC Strategy for Bangladesh (Whitney et al., 1999). In both cases, groups initially formed to carry out specialized communication programs began to work effectively for common purposes. They came to exert an influence that extended far beyond the nuts and bolts of preparing communication materials.

7 *Work together to develop an overall communication strategy and accomplish it.*

Whether you are supporting an integrated national health program or a single disease-centered campaign, one of the best ways to pull the whole team together is to develop a clear strategy that all can support, understand, and share. That includes donors, stakeholders, implementers, and participants. A strategy or strategic design should include: **S**pecific, **M**easurable, **A**ppropriate, **R**ealistic, **T**imebound (SMART) objectives; positioning or framing of the issue so all communication is consistent and emphasizes a positive benefit; a clearly articulated model of behavior change appropriate to the issue; an appropriate choice of channels and media to reach intended audiences; an implementation plan spelling out who is responsible for what; a line-item budget; a work schedule with appropriate benchmarks; and a plan for evaluation (O'Sullivan et al., 2003).

An example is the first phase of the *Stop AIDS, Love Life* program in Ghana. Based on extensive research with Ghanaian youth, an analysis suggested that the “social risks” of using the proven trilogy *abstinence, be faithful, and condoms* (ABC) were perceived as much greater than the “health risks” of not using them (Tweedie et al., 1997). As a result, the program’s strategic design emphasized social risks and norms. The specific objectives included not only increased knowledge about AIDS prevention strategies and about personal risk but also increased interpersonal communication, increased perception that social norms favored protective behavior, and increased practice of safer sex behavior. Social learning theory and stress on social norms were underlying behavior change models. Celebrities (the First Lady of Ghana and top singers and producers), traditional chiefs and Queen Mothers, television and radio spots, entertainment-education variety shows and serial dramas, community rallies in over 200 cities and towns, and rural/video vans with programs in five languages all conveyed the program’s basic messages and reached more than 80 percent of the population (Tweedie et al., 2002).

Assisted by PCS, the Ministries of Information and of Health, the Ghana AIDS Commission, the Ghana Social Marketing Foundation, and multiple private sector agencies developed the *Stop Aids, Love Life* campaign strategy. With a consistent strategy and a coordinated national team, the program achieved wide exposure, participation, and impact. Moreover, the initial campaign facilitated moving ahead on the next strategic objective: fostering compassion for those living with HIV and AIDS and reducing the stigma associated with the disease (Tweedie et al., 2002).

Researchers based the evaluation plan on several data sources: the baseline included two 1998 surveys: the Ghana Demographic and Health Survey (GDHS) and the Ghana Youth Survey (GYS). The July 2001 Ghana Reproductive Health and Child Survival Survey (GRHCSS) provided a mid-term assessment. Ongoing sales of condoms by the Ghana Social Marketing Foundation supplemented survey data and measured changes in demand for condoms. The surveys showed that both men and women who reported high exposure to the campaign were significantly more likely to use

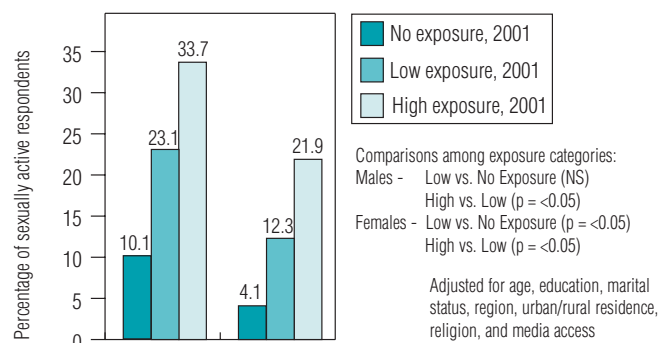


Research with Ghanaian youth suggested that promoting the ABC approach could help reduce the “social risks” associated with HIV/AIDS prevention.

condoms at last sex than those not exposed or less exposed. Condom sales almost doubled after the start of the campaign. Furthermore, highly exposed married men were more likely to be faithful to one partner (Tweedie et al., 2002).

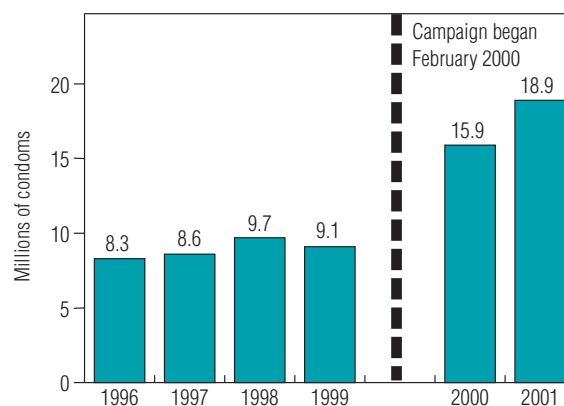
Figure 1.
Percent of sexually active respondents reporting condom use at last sex

(by level of exposure to the *Stop AIDS Love Life* campaign)



Source: 1998 GDHS and 2001 GRHCS

Figure 2.
Annual condom sales in Ghana, 1998-2001

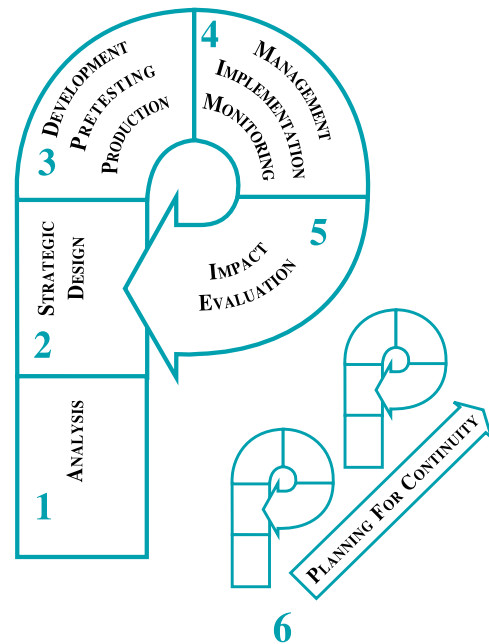


Source: MOH, GSMF, and PPAG sales and distribution figures

Logos or slogans that present a unifying brand or symbol for a program can promote overall strategies. In the Philippines, for example, the dancing children logo with the slogan “If you love them, plan for them” consistently conveyed the strategic theme that family planning did not mean eliminating children but rather being better able to love and care for them. With 98 percent approval, the Department of Health officially adopted the campaign logo as the family planning logo. Such visual symbols not only publicize the program but also serve to unify the team (Rimon & de la Rosa, 1998).

8 Use a common set of practical tools and models so your entire team is speaking the same language and using the same “brand.”

Your whole team needs to know what has to be done, by whom, when, and in what order to carry out a successful program. PCS used a number of frameworks that served as invaluable guides. Most important was the *P-Process*, a step-by-step model for program implementation that moved logically from Analysis to Strategy to Development to Implementation to Evaluation to Planning for Continuity, as illustrated on the right. This model, with relevant intermediate steps, helped numerous teams work together and understand what each step entails. This *P-Process* is now an institutionalized approach that BKKBN, the Indonesian family planning program, applies throughout the country. BKKBN also persuaded the Japanese International Cooperative Agency (JICA) and other major donors in-country, such as UNFPA and Australian AID, to use the same model.



The P Process

Six field guides describe other major program tools— *How to Select and Work with an Advertising Agency* (Greenberg et al., 1996), *How to Write a Radio Serial Drama for Social Development* (de Fossard, 1996), *How to Design and Produce a Radio Serial Drama for Social Development* (de Fossard, 1998), *How to Mobilize*

Communities for Health & Social Change (Howard-Grabman et al., 2003), *A Field Guide to Designing a Health Communication Strategy* (O’Sullivan et al., 2003), and *Field Guide: Setting Up a Hotline* (Stratten & Ainslie 2003).

Many of these tools are widely used. In the field of entertainment-education, for example, the Design Document approach spelled out in the two radio serial drama field guides was essential in developing dozens of radio and television serial dramas since 1995 (Piotrow & deFossard, 2003). In the field of quality of care, counseling and interpersonal communication, the GATHER framework (**G**reet, **A**sk, **T**ell, **H**elp, **E**xplain, **R**eturn) was adopted in at least six languages and a dozen country versions, updated based on practice and research, and now serves as a tool worldwide for counseling interventions and training (Lettenmaier & Gallen, 1987). The **C**ommunity **H**ealth **E**ducation **S**kills **T**ool (CHEST) kit developed in Ghana for use throughout Africa is another example of tools and materials that can be adapted in various settings. For advocacy programs, *The A-Frame for Advocacy* provided an easy-to-follow guide to mobilize support at the grassroots as well as the national level. The *A Frame* was used extensively by the Indonesian BKKBN program for advocacy with district governments. Because all these tools can be easily identified and widely used, they essentially become well-recognized brand names to disseminate even more widely.



Mentor team members to use the tools and models and train host-country trainers to train others in their use.

Consider training with an easily understood program such as the computer training system SCOPE (**S**trategic **C**ommunication **P**lanning and **E**valuation) followed by supervision and mentoring as integral and essential components of any project. Hands-on or on-the-job training is usually most effective, but SCOPE computer software makes training a participatory, hands-on experience. SCOPE is used in workshops by allowing participants to design a communication program using real data by following the *P Process*, upon which SCOPE is based. Training program participants consistently rate

SCOPE as a highly participatory and effective training package. Through direct trainings in 25 country versions and six major languages and through training host-country trainers, SCOPE enhanced communication skills, advanced computer technology, reinforced the need for participatory training modes, and increased the ability to apply practical, proven behavior change communication models in many countries. SCOPE and the *P Process* are now standard training modalities for communication programs in many countries. Moreover, since the *P Process* and SCOPE are equally appropriate for communication campaigns on family planning, HIV/AIDS, polio, maternal mortality, and other fields, they are becoming institutionalized as training tools for the whole field. Indonesia, for example, adopted these tools not only for its own programs but also as a key element in BKKBN's international training program. The Bangladesh Center for Communication Programs and the University of the Philippines use SCOPE to conduct tuition-based communication training workshops for participants worldwide.



SCOPE workshop participants planning their communication strategy.

10 ***Include team members from different disciplines and create opportunities to work together.***

The best implementing teams include organizations and individuals from different disciplines and with different professional skills and community links. Teams should include both government units and NGOs, both nonprofit and commercial expertise, both national and locally based experts, and different health experts. It is especially important to bring in market research and advertising agencies since this type of expertise is rarely available in government ministries or NGOs. Market research firms that made important contributions include Mitra and Associates in Bangladesh, SRI and AC Nielsen in Indonesia, NFO Trends in the Philippines, RMS in Nigeria, and

Research International in Ghana. Advertising agencies that were crucial communication team members include Asiatic Social and Adcomm Lt. in Bangladesh, Campaigns Inc. and Darcy Jimenez in the Philippines, Lintas in Ghana, and PREX and Impact in Nigeria. For entertainment-education programs, scriptwriters, directors, and producers as well as health content experts are essential team members who need to be involved from the start. Coalitions with other agencies can be a useful way to involve community level networks in particular areas. Tools, such as *How to Select and Work with Advertising Agencies* and the two manuals on scriptwriting and production of radio serial dramas, make it easier for different organizations and individuals to understand their different roles and work together effectively. Diverse teams produce creative programs but they require experienced and culturally sensitive management in order to function well.

11 *Develop resource centers to share relevant well-organized materials from other programs.*

Much work and expense, including focus groups, design, pretesting, and revision, go into the development of effective health communication materials. The value of these materials can last well beyond the program for which they were designed. For example, materials developed for the Latin American campaign featuring the singers Tatiana and Johnny in 1985 are still in demand today for organizations developing similar entertainment-education campaigns.

Seeing the actual product saves a great deal of time and expense in project planning and helps health material developers learn from each others' experience.

Recognizing this, the Media/Materials Clearinghouse at PCS and the Population Information Program (PIP) trained resource center personnel in many countries and set up resource centers for health communication in Bangladesh, Bolivia, Egypt, Ethiopia, Ghana, India, Jordan, and the Philippines. As a vital link

The Bangladesh Center for Communication Programs M/MC.



among communicators, these resource centers transmit the knowledge embodied in sample materials and bring agencies involved in similar work into contact to share ideas, research data, and design experience. They provide unique opportunities for team-building and interagency networking, improving quality of communication materials, and saving considerable time and money.

The Media Materials Resource Centre (MMRC) in Lucknow, India, is one example. Set up in 1998, the MMRC amassed the largest collection of health communication materials in Uttar Pradesh, drawing health professionals and visitors from all over the state. MMRC staff also organized public events on special occasions like World Health Day, Population Day, and Breastfeeding Week. They involved newspaper, television, and radio reporters in the activities of the centre, providing media briefings on important public health issues and events. In addition, the MMRC provided clearinghouse services to major organizations such as the State Innovations in Family Planning Agency (SIFPSA) and UNICEF to ensure that health communication materials are distributed to those who most need them.

Chapter Three

ADDRESS KEY PROGRAM ISSUES

DECENTRALIZATION

- 12 Develop new tools and approaches to advocate for health at decentralized levels.
- 13 Station more field staff outside capital cities.
- 14 Develop communication skills at the community level and tailor information to local concerns.

INTEGRATION OF SERVICES

- 15 Adapt the same basic framework and process to develop communication programs for different or multiple health interventions.
- 16 Encourage providers and clients to ask questions and provide referrals on a range of health issues, not only the reason for a specific visit.

QUALITY OF CARE

- 17 Enlist support for quality of care at the highest possible level.
- 18 Build support for quality of care at the community level.
- 19 Use appropriate quality certification and marketing strategies nationally and locally.
- 20 Focus on communication skills as well as technical skills of providers to improve quality of care.
- 21 Plan Observation Study Workshops (OSWs) as a knowledge management tool to show quality of care proponents in one country how model programs work in other countries.

GENDER

- 22 Address a broad range of gender issues in developing health communication programs.
- 23 Seek out women to play an active part in implementing health communication programs.
- 24 Use mass media and entertainment-education to present new role models versus traditional stereotypes for both women and men.
- 25 Observe differences, if any, between treatment of men and women in family health clinics and organize appropriate provider and client training to address inequities.



Some of the key issues that any health communication program will face today include decentralization of government, integration of different health services, quality of care, and gender concerns. All four involve both high-level policy issues and community level transformations. While all four may sound reasonable and desirable when proposed by national policymakers, they can evoke major problems when implemented. These four issues may be interrelated when communities assume more power and seek better quality, more integrated services, and social change. And all are aggravated in conditions of conflict, corruption, or changes in governance. In addressing these challenges, communication programs can often contribute substantially to better results. Lessons learned from experience in the field are discussed below.

DECENTRALIZATION

12

Develop new tools and approaches to advocate for health at decentralized levels.

Decentralization usually means district or municipal authorities will take over the management of health facilities and employment of healthcare providers previously under the control of central ministries of health. The professional status of health personnel may appear threatened when the central ministries or departments of health drastically reduce staff, as in Zambia, Indonesia, and the Philippines, and when most funds and budget authority are transferred to a district, state, or local mayor or council. The new role of the state medical director may be to set health norms and standards, as in Brazil, rather than to provide direct care. In the Philippines, Department of Health staff were transferred from Manila to local government posts as a result of decentralization, causing considerable conflict. Time, tact, and good communication skills are essential in making such major transitions work effectively.

In Indonesia, the decentralization process of major functions from national to district level occurred at the same time that the country experienced a severe economic crisis. The health sector faced an immediate challenge to protect, preserve, and even enhance investments in health in a situation where a great proportion of



The Healthy Indonesia 2010 coalition brought together the government, donors, and NGOs.

government funds were now administered at the district level. The government, donors, NGOs, and the appropriate sector banded together through the Healthy Indonesia 2010 Coalition (Koalisi Untuk Indonesia Sehat – KUIS). In two years KUIS, chaired by a senior Unilever executive, helped set up 55 district and provincial coalitions composed of NGOs, the corporate sector, the media, professional organizations, influential individuals, and faith-based organizations. The coalition's primary purpose was to influence local governments to give high priority to preventive health programs in budget allocations. Tools and data developed at district and provincial levels showed officials and members of the local parliament how preventive health investments were cost-effective in the long run (Rimon et al., 2003). As a result, a number of provinces and districts allocated larger budgets for preventive health programs and community-based programs.

The University of the Philippines at Las Banos and at Diliman developed tuition-based training programs to train local government health staff in health communication and advocacy. The training program has been underway for six years with many of the same staff. It now assists in training carried out by former participants in Vietnam, Indonesia, China, and Mongolia. This type of capacity building is important for the success of decentralized health programs. Because the programs are tuition-based, they provide an excellent gauge of whether local governments are willing to use their own funds to train their staff. They also open new opportunities for universities to play a constructive role in leadership and decentralization, opportunities which The Bill and Melinda Gates Institute at Johns Hopkins Bloomberg School of Public Health now supports.

13

Station more field staff outside capital cities.

As health ministries decentralize, cooperating agencies also need to disperse their technical expertise to the areas where help is most needed. In Nigeria, for instance, programs originally supported from a central office are now assisted by four smaller regional offices and may need to add more. In addition, staff established communication resource centers in each region to collect and distribute relevant

material. In Guinea, the lead communication specialist was stationed not in Conakry, the country's capital, but rather in a provincial capital. More regional or district offices, staffed by more host-country nationals, are important to respond to decentralization. As in government agencies, more decision-making authority can transfer to these offices.

14 ***Develop communication skills at the community level and tailor information to local concerns.***

While mass media like radio and television are powerful and cost-effective means to reach large populations (Hornik, 2002; Kincaid et al., 2003; Snyder et al., 2003), local health officials can supplement, reinforce, and adapt these channels and materials to meet local needs. In Ghana, for example, more than 200 towns and villages held community rallies to support the *Stop AIDS Love Life* program and reinforce national radio and TV coverage. In Bolivia, a traveling health fair with different educational and entertaining presentations on family health known as the *Lilac Tent* was supplemented at every stop by local health officials promoting and providing local services. In Zimbabwe, village launches for the national youth campaign were a major component of the program with special programs in appropriate languages (Kim et al., 2001a). Any time a new program is launched, you have an opportunity to be creative and find ways to stimulate community initiatives and participation.

INTEGRATION OF SERVICES

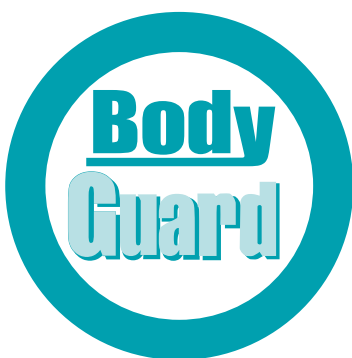
Offering comprehensive integrated services for all family health needs is a major challenge to health care providers. How can minimally equipped, minimally paid personnel provide a broad range of quality services? Yet a client-centered approach must recognize that clients, especially mothers with young children, value having access to a single known, convenient, affordable, and trusted source for such basic health needs as immunization, care for sick

children, antenatal and delivery care, treatment of malaria and other infectious diseases, and accidents. The communication challenge in more integrated services is to help providers meet multiple needs for counseling and services and to give clients the information they need to access relevant services.

15 **Adapt the same basic framework and process to develop communication programs for different or multiple health interventions.**

You can follow the same basic steps (analysis, strategic design, message development, implementation, evaluation, and planning for continuity) in developing communication programs for family planning, HIV/AIDS prevention, immunization, control of polio, maternal mortality, and other health issues. While the content and actors may be different, the basic process is similar, as applied in communication programs in Bangladesh, Ghana, Nicaragua, Nigeria, Indonesia, and elsewhere.

Following the same process makes it easier for all health personnel to understand the program's implementation, to prepare for newly stimulated demand in each area, and to work together on continuing campaigns and programs. Even those outside the normal health system—such as market research firms, advertising agencies and commercial sponsors—can improve their skills and collaborate better when following a familiar framework. In Nicaragua, for example, PCS used the same process to develop the *Estrella Azul* (Blue Star) hygiene and clean water program after Hurricane Mitch, the *Juntos Decidimos Cuando* (Together We Decide When...) campaign to promote sexual responsibility among youth, and the social marketing campaign for *Bodyguard* condoms. The *Bodyguard* condoms campaign illustrates another type of integrated approach since the condom was promoted for dual protection against both STDs and unwanted pregnancy (Ainslie et al., 2001).



BodyGuard condoms promoted dual protection for couples in Nicaragua.

16 *Encourage providers and clients to ask questions and provide referrals on a range of health issues, not only the reason for a specific visit.*

To gain full benefits from integrated service delivery programs, providers can ask family planning clients if their children were immunized, ask mothers coming for immunization if they want family planning, ask pregnant women if children's growth charts are up to date, and ask husbands if their families have anti-malaria bednets. Often, clients are too uncertain, intimidated or shy to ask questions, but providers can take the lead in supporting integrated services simply by asking such questions (Kim et al., 2001b).

Train providers to refer clients for these other services. Relevant services can be clearly identified regarding location, time, and other issues both within facilities and for outreach workers. You can also encourage clients to ask about other services. Group meetings and educational sessions in clinic waiting rooms are one approach. Posters and radio spots can suggest questions to be asked. Although in many situations the provider may be better placed to ask the client about relevant health problems, it is important that clients are also empowered to ask questions and insist on responses addressing their personal concerns.

Referral to other clinic services, sometimes called "in-reach," can help clients get maximum benefit from each clinic visit (Lynam et al., 1994). In Bangladesh, India, and Ethiopia, PCS trained family planning workers to raise questions about other health issues and then refer clients to the appropriate service. Although an overload of questions or good advice may be counter productive, a few well placed questions from providers or from clients can lead to additional relevant treatment.

The Green Umbrella/Smiling Sun program in Bangladesh grew from a single purpose outreach design to a package of integrated family health services offered in satellite and district clinics. Integrated family service centers clearly marked by a Smiling Sun logo in addition to the Green Umbrella led to new norms among service providers to meet a wide range of health needs. At the same time, it signaled to clients that multiple services were available under one roof (Do & Kincaid, 2001).



QUALITY OF CARE



*Improving the quality of care in reproductive and family health services is an important, difficult, and long-term task. Yet it is essential in order to ensure full use of cost-effective preventive services and to maintain client confidence in curative services. From 20 years of experience and evidence, it is clear that “the impact [of quality improvement] is greatest and more likely to be sustained when initiatives address both supply and demand” (Heerey et al., 2003). Good communication is essential to both sides of the equation since providers (the supply side) need to be good communicators and clients (the demand side) need to help define and expect to receive good quality care. USAID’s MAQ initiative (Maximizing Access and Quality) led the way in promoting these issues (For a comprehensive description of PCS and CCP projects that address these issues and MAQ, see *Improving The Quality of Care (2003)* by M. Heerey, A.P. Merritt, and A.J. Kols, and the CD-ROM, *Client Provider Communication: Successful Approaches and Tools*).*

17 Enlist support for quality of care at the highest possible level.

Quality of care programs depend on political will, preferably extending from the highest levels of health ministries to operational services, communities at the local level, and NGOs. Political will and quality champions at the top were crucial factors in launching the Gold Star Quality Program in Egypt. It consisted of 101 quality indicators set by expert groups and implemented through a national network of over 3,800 outpatient service units. Village and religious leaders often helped inaugurate these Gold Star clinics, thus encouraging community ownership in quality improvement. Stimulated by competition from the private sector, Egypt’s top health officials committed to a program that became a worldwide model.

Other countries have endorsed similar approaches at high levels. In the Philippines, the Department of Health initiated the *Sentrong Sigla* program to certify and honor high quality local government health centers. Because of a high level of support and its popularity, the program survived three changes in health ministers and won the

Population Institute's Global Country Award. Similarly, in Brazil health leaders in Ceara and Bahia states took the lead in developing statewide PROQUALI programs focusing on improved service delivery. Community leaders' involvement ensured that quality improvement effort at the clinical level responded to community needs as well as mobilizing community members to use these services more.

Quality may also be demand-driven by modeling quality for policymakers and the public through TV and radio dramas. Such dramas, like the Green Umbrella series in Bangladesh, portray well-trained providers. Role models of caring providers raise expectations for better behavior and treatment so both providers and clients are motivated to respond. Both should also demand that quality improvements be sustained by local leaders.

18 *Build support for quality of care at the community level.*

Where national priorities do not exist or are difficult to implement because of social or cultural gaps between providers and clients, community-defined quality of care programs are becoming increasingly important. In decentralized programs, the initiative for improved quality may rise from local level stakeholders or NGOs rather than the central government. In Peru, Zambia, and Francophone Africa, some communities played an active role in defining quality standards and working with service providers to apply them to local facilities. The *Puentes* project in Peru helped bridge the social gap between providers with a Spanish-speaking, urban background and their clients in indigenous communities. Through the use of video and facilitated dialogue between providers and clients, specially trained Ministry of Health staff helped both parties come to a consensus on the definition of quality and create and implement joint action plans to improve health services (Howard-Grabman et al., 2001). Tanzania staff adapted major elements of the *Puentes* model as part of the Quality Improvement and Recognition Initiative (QIRI) there.



The Puentes Project in Peru involved the community in improving their own quality of care.



19 *Use appropriate quality certification and marketing strategies nationally and locally.*



The Sentrong Sigla logo became the seal of approval for quality service delivery in the Philippines.

Quality certification programs are an increasingly important model for comprehensive quality improvement. They are only effective in improving quality of care, however, if workers perceive a benefit in achieving certification – and if potential consumers are aware that there has been an improvement in quality. Over the last decade, quality improvement professionals developed and refined the model of quality recognition to couple marketing strategies with regular assessment of service delivery performance as measured against a set of predetermined standards.

In this context, marketing campaigns combining mass media, community mobilization, and other communication activities increased consumer demand for quality and developed a culture of quality among service delivery staff. A logo or symbol is key when marketing quality of care programs because it will come to represent quality in the minds of both providers and clients. Examples of quality recognition logos include Egypt's Gold Star, the Philippines' *Sentrong Sigla*, and PROQUALI in Brazil. In the Philippines, clients quickly began to recognize the *Sentrong Sigla* logo as a seal of approval for better services after it was shown on television, placed on qualifying clinics, and featured in news stories about top-performing facilities. In Brazil, the PROQUALI star symbolized the new client-oriented model for women's health services. State officials accredited PROQUALI clinics when they met 90 percent of 61 criteria in five core areas and ceremonially presented the clinic with a quality symbol plaque. PROQUALI publicized its logo locally through community events as well as through community radio and street dramas. After two years, visits to the four model PROQUALI clinics more than doubled (Ainslie et al., 2000).

In the Philippines, country staff used marketing to establish and promote the FriendlyCare Foundation, a private-sector provider of accessible and affordable quality family planning and reproductive health services. Founded in 1999 by top Filipino business leaders, FriendlyCare filled the market niche between free government health care and expensive private clinics by providing services to middle- and lower-income families willing to pay for affordable, high-quality

family health and planning services (McKenzie et al., 1999). FriendlyCare's innovative retail approach to health care included clean, brightly colored storefronts located in retail areas with service and product prices clearly posted in the waiting area (Negrette, 2003). Media and community-based activities promoted FriendlyCare's promise that quality family planning services were available at an affordable price and every client, regardless of social class, would receive the same friendly, respectful care.

20 *Focus on communication skills as well as technical skills of providers to improve quality of care.*

While technical aspects of health care are crucial – infection prevention, proper use of drugs, and correct procedures and information – clients are powerfully influenced by personal interaction and communication with providers. Client perceptions of improved quality depend strongly on how they are greeted, treated, and counseled in health facilities. Therefore, observe and analyze client-provider communication, develop cue cards and other easy-to-use guides, and train providers to be polite, ask questions, listen carefully to clients, reply clearly, and provide the information clients want in order to make their own informed decisions. Once again, the slogan “*Learn to listen, listen to learn*” is a useful guideline that applies to individual counseling as well as to national strategy development.

In Indonesia, counseling training is followed by skill-reinforcement through self-assessments and peer reviews.

Counseling training is essential and should be followed by skill-reinforcing activities like self-assessments and peer review to make new skills more sustainable, as demonstrated by research in Indonesia (Kim et al., 2003). A counseling framework, such as GATHER, adapted to different health needs, is a useful tool for training counselors and other health care providers. Supervisors need to monitor counseling and interpersonal communication as much as they monitor technical skills. Supervised practice and evaluation help to reinforce this training.



21 *Plan Observation Study Workshops (OSWs) as a knowledge management tool to show quality of care proponents in one country how model programs work in other countries.*

Observation Study Workshops (OSWs) provide a means to facilitate transfer of both explicit and tacit knowledge. The workshops can effectively jumpstart complex communication initiatives that require a common vision and strong commitment among a core group of champions. They should not be dismissed as mere junkets.

To achieve the best results and overcome the perception that each country is unique and cannot learn from the practices of others, follow these basic guidelines:

- Select participants with the power to make policy and program changes when they return home and the will to work with one another as necessary;
- Engage participants in the process of establishing the objectives and agenda;
- Identify places to visit based on the quality of their programs and the willingness of host facilities to take the time to help others;
- Accompany all OSWs with knowledgeable experienced staff to facilitate discussions;
- Facilitate work sessions throughout to synthesize lessons learned and analyze applicability to participants' own programmatic context;
- Require written quality improvement workplans at the end of the workshop from all institutions participating; and
- Follow-up on implementation of the workplans with continuing technical assistance visits and self-assessments.

Nine highly qualified Filipinos, including representatives of the Department of Health, FriendlyCare Foundation, University of the Philippines, and the Philippine Health Insurance Corporation, participated in an OSW focusing on quality of care. They visited model facilities such as Kaiser Permanente and Johns Hopkins University Hospital, met with USAID and international experts, and

completed detailed workplans to take back to the Philippines. The participants applied the lessons learned to improve programming for each of their institutions.

An OSW to Egypt's Gold Star and Francophone Africa's Cercle d'Or (Gold Circle) programs played a crucial role in stimulating the Tanzania quality improvement program. It helped Tanzanian health leaders, including the head of Health Sector Reform, adapt features from the other programs while developing a sense of ownership for their own distinctive program. PCS helped BKKBN's International Training Program to evaluate the impact of their OSWs with Bangladeshi participants. The evaluation conducted by two university professors in Bangladesh concluded that districts in Bangladesh that sent groups of participants to observe the Indonesia program were more likely to perform higher than other districts (Howlader & Chakma, 1997). At the same time, the other programs and the individuals hosting the OSW described the experience as a *win-win* exchange in which they learned more about their own program simply through the process of telling their story as well as learning from the experiences described by their visitors.



The Gold Circle program stimulated improvements in quality in Tanzania and other African countries.

GENDER

Gender affects all aspects of communication and health care. Communication among and between men and women is often rooted in cultural contexts that place women at a disadvantage within the family and the community. Women often have little opportunity to speak up or initiate changes. When they try, they are often not listened to. Even where their own health problems are involved, women are rarely the prime decision-makers. Paradoxically, family health is an area where women provide most hands-on care for others while facing serious but often unattended health risks for themselves, especially during childbirth. Yet at the same time, progress in health care, for the whole family, needs to be based on mutual understanding and support between women and men.

22 Address a broad range of gender issues in developing health communication programs.

Apart from the well-accepted principle of segmenting audiences for different gender messages, gender issues should play a role in most aspects of health communication. The Gender Guide, developed with assistance from the Centre for Development and Population Activities (CEDPA), provides a broad perspective incorporating gender concerns in every step of the *P Process* (Zaman & Underwood, 2003). It includes

- **RESEARCH AND ANALYSIS** (*How do women and men perceive the desired behavior? What special barriers do either sex face in achieving it?*);
- **STRATEGIC DESIGN** (*What is the strategic and practical benefit for women and for men? What objectives, behavior change models, and channels of communication apply to each?*);
- **MESSAGE DEVELOPMENT** (*How will women and men be exposed to and interpret specific messages? What role models are embodied in those messages?*);
- **IMPLEMENTATION** (*What role will women and men both play as program managers?*);
- **EVALUATION** (*How were women and men each affected by the program? Did any gender norms change as a result?*); and
- **PLANNING FOR CONTINUITY** (*How will changes and benefits be sustained?*).

Abtissam, from a conservative Yemeni family, became a nurse to raise her family's standard of living.



The Arab Women Speak Out (AWSO) project illustrates how gender-sensitive design and implementation can have a grassroots impact. *Arab Women Speak Out* began by researching the lives of village women who could serve as role models for their peers. Ten video and print profiles of these women were distributed through interested women's organizations and media in the Arab world. Training manuals and workshops encouraged women to seek more education, start small businesses, play an active role in their communities, and mentor other women. Since its launch in 1999,

nearly 100,000 women from six Arab countries – Egypt, Jordan, Lebanon, Algeria, Tunisia, and Yemen as well as Palestine – have participated. A 2001 evaluation found that the participants were more than twice as likely as non-participants to engage in community health programs, start their own businesses, and advise others (Underwood & Jabre, 2002). The project’s broad culturally appropriate approach empowered these women to reject stereotypes and create their own opportunities, usually with increasing support from their husbands.

23 *Seek out women to play an active part in implementing health communication programs.*

In many countries, women represent untapped talent that faces stiff competition from established male professionals. By seeking out women leaders to mentor other women and young women who are starting out, you can often identify talent in the field of communication that is available, reasonably priced, and personally committed to women’s health issues. This was true in Pakistan, for example, where women scriptwriters and directors produced a powerful television series, *Aahat*, on the value of the girl child and several videos on family planning and girls’ education. Host-country women wrote several dramas in Ghana and Zambia; worked as account managers for advertising agencies in Ghana and Bangladesh; and became PCS program managers in many countries. In Nigeria, the first democracy and governance project focused specifically on strengthening women’s organizations so they could be more effective advocates for women’s and family health, both nationally and at the community level (Babalola et al., 2000).

24 *Use mass media and entertainment-education to present new role models versus traditional stereotypes for both women and men.*

Mass media are a powerful tool to establish new social norms and promote social change and gender equity. The serial dramas around the *Green Umbrella* program in Bangladesh all featured competent

young women health workers who rejected passive roles in the community and became active and ambitious agents of social change. Similarly, dramas in Pakistan, Indonesia, Egypt, and Turkey among others focused on education for girls, later marriage, and a proactive role for professional women (Piotrow & deFossard, 2003).

Gender issues are relevant for men also. Programs and spots designed for couples and men in Bolivia, Brazil, Peru, Morocco, Egypt, the Philippines, Nigeria, Indonesia, and Jordan showed men as caring partners and receptive to women's concerns. Men and women both initiated discussions about family planning and health. TV spots in Cameroon emphasized that even macho soccer heroes like superstar Roger Milla care about the well-being of their wives and children. Working with CECAFA, the men's football federation in Africa, PCS recruited a "dream team" of caring men to present a shifting picture of gender relations and male partnership in reproductive health. (Awsum et al., 2001).

25 *Observe differences, if any, between treatment of men and women in family health clinics and organize appropriate provider and client training to address inequities.*

Men do not often accompany their wives to clinics, but when they do they are usually treated differently by clinic personnel. Men are much more likely to be listened to, encouraged to ask questions, treated with

respect, or praised (Kim et al., 2000).

Women deserve the same respect.

Address this issue by using tapes or videos to document these disparities—as PCS did in Indonesia, Kenya, Mexico, and Peru—and to establish

Discussing gender issues in Bangladesh.



training programs for providers to address them (Kim et al., 2000a and 2000b). These programs, as discussed above, need to train and supervise providers to be more respectful and to encourage clients of both sexes, but especially women, to be more insistent on having their concerns addressed.

Chapter Four



STIMULATE COMMUNITY PARTICIPATION

- 26 Work directly with communities to help them define their own needs and develop their own solutions.
- 27 Identify key groups or segments of the population and develop specific programs with them and for them.
- 28 Work with youth leaders and active youth organizations to develop programs.
- 29 Build coalitions to enlist broad and strong local participation.
- 30 Work with entertainers and celebrities to reach large numbers of people and engage hard-to-reach audiences.
- 31 Use appropriate new information technology to involve more people.

Successful communication programs cannot simply be imposed on people from above. They need to be built up with ever-increasing participation by the intended audiences, stakeholders, and beneficiaries. The old communication paradigm, where messages are transmitted by a sender in a linear fashion to a receiver who then acts upon them, has been transformed. Today's communication programs are more of a dialogue where the intended receivers interact with the senders (or change agents) to fashion messages that respond to receivers' needs and priorities. Twenty years of experience with increasingly participatory communication programs suggests several ways to improve popular participation and community leadership in health communication.

26 *Work directly with communities to help them define their own needs and develop their own solutions.*

You can identify communities and leaders within communities who are ready to take action. Whether stimulated by natural disasters like Hurricane Mitch, community recognition of intolerable conditions, or the initiative of outside change agents, many communities are ready to play a more active role in health care. In the Philippines, the *Appreciative Community Mobilization* process adapted from Appreciative Inquiry by Save the Children is a useful approach to help communities build on their strength to achieve their dreams for improved family health. In Bolivia the *Sistema Epidemiologico Comunitario Integral* (SECI) program with Save the Children is a community-based health information system that provides community members with information about their community health indicators in easy-to-understand pictorial banners. This information is used by the community and service providers to analyze their system, set priorities, plan action, and monitor and evaluate progress over time. In Peru, the *Puentes* project is an ongoing quality improvement program to increase shared responsibility for improved quality between communities and service providers based on mutually defined definitions of quality.

In Bangladesh, the Jiggasha approach, based on the South Korean model of Mothers Clubs that discuss community issues, encouraged

Bangladeshi women to meet in groups with health workers rather than individually (Kincaid, 2000). In all these programs, village social networks help to reinforce desired health behaviors.

Use *How to Mobilize Communities for Health and Social Change* as a guide to build community capacity to improve health (Howard-Grabman & Snetro, 2003). Also use the social change indicators, developed with support from the Rockefeller Foundation, to evaluate step-by-step the impact of community involvement in health and social change (Figueroa et al., 2002). These indicators can be used to stimulate and track social change through a process that includes catalysts for action, community dialogue, collective action, individual change, social change, and ultimately, societal impact.

27 **Identify key groups or segments of the population and develop specific programs with them and for them.**

People associate with their peers and organize around common interests. Therefore women's groups, men's organizations, young people's clubs, and professional or other interest groups can play a crucial role in communication programs. For example, in the Near East, the *Arab Women Speak Out* project gave a voice to town and village women who could be role models in their communities. Their achievements, often personal and family-oriented, are those to which other women can relate and aspire. Through multiple training sessions with women's networks, AWSO helped Arab women participate in and influence family and community events (Underwood et al., 2001). In Nigeria, the democracy and governance project played a similar role in empowering women to participate in the political process. Women who were exposed to the program were twice as likely to vote than women who were not (Babalola et al., 2000).

Men not only are a crucial audience for health care but also need to be active participants in communication programs. To involve men and make them active partners, PCS developed athletic contests, like bicycle races in Uganda; co-sponsored major sports events like the football tournaments in Kenya and Nigeria; encouraged sports heroes to endorse safer sexual behavior like Roger Milla in Cameroon and

Julius Aghahowa of Nigeria's Super Eagles; arranged local, national, and international concerts such as the 2000 International AIDS conference in Durban; and produced radio serial dramas with narratives designed to appeal to men (Robey et al., 1998).

Generate greater involvement in health programs by segmenting populations in groups that form natural networks and help them develop and participate in activities of special interest to them. But partnership and collaboration between the sexes rather than conflict or competition for control work best in the long run.



Men need to be active participants in communication programs. Develop programs for men around activities such as soccer matches.

28 **Work with youth leaders and active youth organizations to develop programs.**

No part of the population is more important to reproductive health programs than young people. Young people often do not want to be told what to do. They want to be active and learn to make their own decisions, informed but not pressured by elders or experts. So you need to enlist committed, active, and creative young people to develop their own programs, like the Youth Variety radio show in Kenya (Kiragu et al., 1996); the Communication for Young People project in the Philippines; *Straight Talk*, the radio show in Uganda (Lettenmaier et al., 1999); *Trendsetters*, the number-one youth lifestyle magazine in Zambia; and the Family Life Education Program in Jordan, where young people address their own concerns for the future, including marriage and family. Programs in Bangladesh, Nicaragua, Ghana, South Africa, and Zimbabwe also depended on young people to help develop appropriate materials, launch national campaigns, and generate enthusiasm and action among their peers.

Youth programs need not deal only with adolescents. In Ecuador, the population-environment television show *Arcandina* designed for 7-10 year olds stimulated school contests, parades, tree planting, and



Ecuador's population-environment television show, Arcandina, stimulated school contests, parades, tree planting, and support for specific conservation projects.

support for specific conservation projects (Aguilar, 2002). Children who become active in environmental programs at an early age may well grow up to be strong adult supporters. At the same time, parents can be influenced by their children's reactions. In Kenya and elsewhere, many parents listen to or watch programs for young people because they want to know what young people are thinking and doing. Parents learn from these programs and are better able to discuss these issues with their children (Krenn et al., 1998).

29

Build coalitions to enlist broad and strong local participation.

Coalitions represent a further step in team-building. Organizations as varied as Rotary Clubs, religious organizations, professional groups, and commercial firms can join together to work on a specific problem of concern to all. The Healthy Indonesia 2010 Coalition, for example, links many such different groups in a national coalition to support better health. The coalition mobilized local NGOs to work at the community level, advocating better health care to the provincial governors and district councils that determine budgets. In decentralized programs, coalitions that include national organizations with local branches and programs can be powerful participants and advocates in health communication programs. In fact, local organizations often take the lead and pressure national groups to be more active.

30

Work with entertainers and celebrities to reach large numbers of people and engage hard-to-reach audiences.

Entertainment is a powerful tool to capture attention, develop emotional rapport, and mobilize audiences who do not respond to more conventional means of education. Music, like the songs of

Tatiana and Johnny in Latin America, Lea Salonga in the Philippines, and King Sunny Ade in Nigeria, were top hits among young people and their parents. The message was well understood – wait before you become sexually active. Today, *Africa Alive* has prompted entertainers in six countries to pay more attention to HIV/AIDS prevention and to offer both advice and solace through music and drama.

More than 50 serial dramas on radio and television reached millions of listeners and viewers in the last two decades with messages about family planning, child survival, HIV/AIDS, girls' education, maternal health, and gender role models (Piotrow & de Fossard, 2003). Work with local talent, following the Design Document process, to produce dramas that educate while they entertain and that are more memorable and effective than merely giving instructions (de Fossard 1997, 1998; Piotrow & de Fossard, 2003). Since the impact of any communication programs depends heavily on the extent of reach or exposure, mass media programs that attract large audiences like *And the Nile Flows On* in Egypt, *Shabuj Shathi* and *Shabuj Chhaya* in Bangladesh, and *Journey of Life* in Ethiopia usually have the greatest impact.

Moreover, entertainment is participatory and draws audiences in. Whether they sing along, dance, discuss the plot, or identify with lead characters, people respond and share in the emotional appeal. Street theatre, local groups, and community radio often improvise using some of the same characters and plots as those in national media. Thus mass media and especially entertainment-education stimulate a participatory process and parasocial interaction that can reach out and influence the behavior of large populations.

31 **Use appropriate new information technology to involve more people.**

Like mass media, information technology (IT) is not a one-way street. If used creatively, it can draw in new audiences and impart useful information, give advice, and offer leads for more active involvement. For example, telephone hotlines have worked in reaching young people and their parents in urban areas of the Philippines, Nigeria, and South Africa. But to be effective, programs need continuing resources,

Selected Entertainment-Education Radio and Television Serial Dramas and Variety Shows

Assisted by Population Communication Services

Country/ Date	Name/ Format	Main Messages: Health and Social	Plot Synopsis	Evaluation Data/Impact	Relevant Points/References
ETHIOPIA 2001-2002 Radio	<i>Journey of Life</i> SERIAL DRAMA 26 20-minute episodes	PLAN FAMILIES and control epidemic of HIV/AIDS by taking preventive measures. SMALLER families will improve quality of life. Women deserve equality.	AZEB , raped by employer, gives child for adoption but learns it will be sold. MISUNDERSTANDING with husband threatens both with HIV/AIDS.	AMONG REGULAR radio listeners, 90% heard programs and 90% of those recalled content. 93% reported changing behavior.	FIRST E-E radio serial drama in Ethiopia, extended from the initial 13 to 26 episodes. (Ferrara et al., 2002)
GHANA 2002 - present Radio	<i>He, Ha, Ho</i> MAGAZINE SHOW 78 15-minute episodes	PROVIDE correct home-based care for malaria and child health. FAMILIES and communities need to take the lead in health care.	FORMAT includes expert advice, music, mini-drama, testimonials, street interviews, poetry, letters.	PLANNED PRE-POST surveys with listener group monitoring	MEANS HEALTHY HAPPY HOME won WHO "Roll Back Malaria" Excellence Award in 2002.
NEPAL 1995 - present Radio	<i>Cut your Coat According to Your Cloth</i> SERIAL DRAMA 52 15-minute episodes in 4 series	USE MODERN family planning methods, with focus on couples with unmet need. SPOUSES and health providers should communicate and treat women with respect and give more attention to women's health.	A YOUNG couple and family struggle to overcome traditional barriers to health with help of community health worker.	AFTER EXPOSURE to both programs and interpersonal discussion, health worker skills improved; clients improved their self-efficacy, attitude towards clinics, and adoption and use of FP.	SHOWN with distance learning for providers – a unique combination and rebroadcast. Based on these dramas, local NGOs created new activities including street theater, radio listening and literacy groups. (Storey et al., 1999; Boulay et al., 2002; Storey & Boulay, 2002)
BANGLADESH 2000 Television	<i>Shabuj Chhaya</i> (Green Shade) SERIAL DRAMA 13 30-minute episodes	USE CLINIC services, especially Green Umbrella clinics; immunize children; use vitamin A, ORT, FP for newlyweds; give information to adolescents; care for persons with HIV/AIDS; Respect professional women health workers.	Doctor Jalal tries to persuade rural and urban people to take more responsibility for their own health, visit clinics and care for PLWAs.	25 MILLION+ viewers. Over 600,000 letters received: viewers significantly higher in HIV/AIDS knowledge and FP use than non-viewers.	EACH EPISODE ends with a quiz and prize. Audience members mail in responses for weekly drawing. Commercial sponsorship by Aromatic Cosmetics. (Hasan, 2001)
BOLIVIA 1997 Television	<i>Piel del Luna</i> (In the Light of the Moon) SERIAL DRAMA 14 30-minute episodes	MORE COUPLE communication, FP, reproductive health, infidelity, sexuality, gender, and violence, abortion, women's self-esteem, and homosexuality. Gender issues stressed	WHEN TWO couples in high school choose different paths, the couple not using FP faces unwanted pregnancy and other problems.	95% of the audience recalled the need to use contraceptive methods. 82% valued talking about sexuality most highly.	DRAMA during first 20 minutes of program, plus a 10-minute segment of country-wide discussion by teens. SHARED 1ST PRIZE in 4th Latin America film festival with <i>Time for Love</i> (Peru). (Valente, 2001)
ECUADOR 1996 - present Television	<i>Arcandina</i> (Andean Ark) VARIETY SHOW SERIAL DRAMA 100+ 30-minute daily episodes	SAVE WATER , trees, paper, electricity. Decrease litter and air pollution. CHILDREN can be active to protect their communities.	THE ADVENTURES of the Arcandina crew show population-environment links in music and information segments with appealing puppets for 7-10 year olds.	KNOWLEDGE and attitudes on population-environment links (e.g., erosion, water.) improved and conservation behavior increased.	DAILY TELEPHONE contests. 2002 conservation Achievement Award from US National Wildlife Federation for Best International Program in population and environment. (Aguilar, 2002)

often from commercial sources such as the Philippine Long Distance Telephone Company (Rimon et al., 1994); trained counselors; youth and other user-friendly facilities for referral; and promotion to inform potential users (Stratten & Ainslie, 2003).

The Internet is another source of potentially useful – but also potentially dangerous – information. Young people and those with access to cyber cafes can learn a lot via the Internet, but health care facilities and information sources need to be proactive in developing and promoting accessible, reliable, and sympathetic websites to reach users with accurate information. The Internet is too valuable a resource to be overwhelmed by rumor-mongers, pornographers, and commercial exploiters. When, as in some Nigerian and Latin American programs, Internet centers and cyber cafes can be closely linked with youth outreach programs and youth servicing organizations, even more young people can find informed guidance. Within clinics, youth centers, universities, and schools, computers can help people seek answers to their problems, connect with other like-minded groups, and find new resources. In Peru, for example, PCS collaborated with the Population Council to use computers in clinics for confidential counseling for young people. *Isabel*, the electronic counselor, proved even more popular than personal counseling for young people who wanted accurate information but preferred to receive it anonymously (Aguilar, 1998).



Isabel, the electronic counselor, proved even more popular than personal counseling for young people.

Chapter Five



DEAL WITH CONTROVERSY

- 32 Pretest all materials and language and respond to participant concerns.
- 33 Establish and maintain good working relations with the media before controversy occurs.
- 34 Line up allies and experts to help make your case.
- 35 Manage controversy to present more evidence of the health and other benefits of your program but make small concessions if necessary.
- 36 Find evidence of public support to counteract critics.

Any highly visible program like a health promotion campaign can generate controversy. Even widely accepted programs like child immunization and especially programs related to sexual behavior and youth can provoke opposition. Moreover, government officials and donor agencies are extremely sensitive to any form of controversy. Therefore organizations that carry out health communication programs need to be prepared at all times to deal with controversy.

32 Pretest all materials and language and respond to participant concerns.

In retrospect, it is possible to trace many public controversies to insufficient pretesting and/or insufficient reaction to pretesting comments. From an early controversy in Kenya, where a TV show was taken off the air because a young girl slapped an older “Sugar Daddy” who tried to seduce her, to more recent pronatalist opposition in the former Soviet Republics, hindsight suggests greater attention should be paid to critical comments during pretesting. For example, in the Kenya TV episode, it was not the attempted seduction but rather the image of a girl slapping a man that aroused opposition; the message of refusing sex could have been conveyed more acceptably, though perhaps less dramatically without the slap, as pretests suggested. Alternatively, the TV drama could have aired after primetime. In former Soviet Republics, the term “family planning” reminded many people of socialist planning and recalled coercive central government control. “Safe motherhood” or “child spacing” were better terms to use. To avoid unnecessary criticism, all materials should be pretested with relevant audiences, fully explained to government officials and donors, and modified as necessary to avoid controversy over minor issues.

33 *Establish and maintain good working relations with the media before controversy occurs.*

Media relations are a critical element in effective communication. Staff of health and health-promoting organizations need to assign a senior staff person to media relations; organize regular briefings, on-site visits, recognition and awards for good coverage; provide accurate, easy-to-understand information promptly; and, if possible, arrange media training programs or trips to enhance the careers of would-be health journalists. In Bangladesh, Brazil, Nicaragua, the Philippines, Peru, Ghana, Ethiopia, Kenya, and Zambia, PCS organized special programs to orient the press to new developments in health, to show them how to use resources like POPLINE or CD-ROMs and the Internet, and to help them travel to international workshops or conferences. In Bangladesh, PCS staff held concurrent workshops with the media and program specialists to help them work

better together. In Nigeria, supporting the Nigerian Association of Women Journalists not only gave new impetus to health care reporting but also helped women provide their own unique perspective on health and other issues (Babalola et al., 1999). You can never do too much to keep the press informed about health issues and equipped to provide accurate coverage when controversies arise.



The Nigerian Association of Women Journalists not only gave new impetus to health care reporting but also helped women provide their own unique perspective on health and other issues.

34 *Line up allies and experts to help make your case.*

When any program is attacked, credible allies trusted by the press and the people are indispensable. Be sure to have immediate access to the most relevant supporters, especially in the government, and that they have access to accurate information. In the Philippines, when allies of Opus Dei charged wrongfully that tetanus toxoid vaccines for pregnant women contained abortifacients, the Department of Health immediately called on the World Health Organization and other international and Philippine authorities to deny the charges. In Zambia, when conservative religious leaders denounced TV spots with girls talking about condoms for protection against disease, youth organizations responded strongly in support of the spots. While the government hesitated, youth groups defended the right of the girls as well as boys to know about condoms and to insist on protection. In Armenia, when pronatalist groups denounced family planning as genocide, the well-briefed Ministry of Health granted interviews to journalists, organized meetings with interest groups, and held press conferences to present relevant statistics.

35 *Manage controversy to present more evidence of the health and other benefits of your programs, but make small concessions if necessary.*

Criticism and controversy attract public attention and thus provide an excellent opportunity to publicize even more of the benefits of your program. To blunt criticism of contraception in Bolivia, for example, program staff emphasized the reduction of high rates of maternal mortality. Thus publicity about saving mothers' lives kept that issue high on the agenda and deflected religious concerns about family planning. In Armenia and other former Soviet Republics, the main thrust of campaigns was to replace abortion with modern family planning methods. Whenever critics objected or complained of genocide, officials replied with statistics on the dangers of abortion, links between abortion and later infertility, and the worldwide data on the use of safer, effective modern contraceptive methods such as pills, injectables, and IUDs. In Armenia, community participation in some areas of the country prevented the backlash experienced in areas

where no participation strategy was used. Still facing opposition from Opus Dei and the Catholic Church, the Philippines 2000 campaign focused on good husband-wife relations and the value of modern contraceptives in keeping wives young, attractive, and still interested in a healthy sexual relationship.

In both Bolivia and the Philippines, opposition from the Catholic Church is a continuing source of controversy. In both countries, the church objected to television spots that mentioned specific modern contraceptive methods. In Bolivia, program staff and opponents reached a compromise to include specific references to natural family planning and to include a TV spot on natural methods (Valente et al., 1996). In the Philippines, a further compromise in one campaign eliminated television spots on family planning methods and only used radio. Unfortunately, the radio spots reached and influenced fewer people, but the campaign itself continued (Kincaid & Do, 2003). At times, involving the critics from the beginning in the design of the program helps prevent minor disagreements from becoming major conflicts.

36 *Find evidence of public support to counteract critics.*

Evidence of popular support is often the best answer to criticism. In the Philippines, two scientific polls conducted by reputable polling agencies showed that voters were more likely to support candidates who endorsed family planning. In Armenia, clinic attendance increased despite criticism, showing that women wanted to use family planning as a substitute for abortion.

Clinic attendance in Armenia increased despite criticism, showing popular support to counteract critics.



Use all relevant evidence of popular interest and support to answer critics. Communication programs can use DHS surveys or even informal polls to show that people want accurate information,

want information from TV and radio, and seek out a choice of supplies and methods, and accessible, affordable, high-quality services.

Chapter Six



MEASURE HOW THE PROGRAM WORKED

- 37 Plan for evaluation at the start of any intervention.
- 38 Use and clearly state a theoretical behavior change model to guide your program.
- 39 Use available external resources, especially Demographic and Health Surveys (DHS), which provide comparable cross-sectional data over many years.
- 40 Develop multiple research designs and data sources to reinforce your conclusions.
- 41 Recognize and control for confounding variables such as changes in policy, other programs or promotions, or selective individual exposure.
- 42 Combine qualitative and quantitative methods.
- 43 Design evaluations not only to measure impact but also to improve future programs.

Evaluating communication programs and measuring their impact pose special problems. In the early 1980s the Director of USAID's Population, Health and Nutrition Center challenged PCS "to prove that communication works." This challenge stimulated many discussions, application of several different research designs, and multiple publications. Because communication programs alone – without an enabling environment of facilities, supplies and personnel – can probably not achieve lasting health behavior change in most cases, the relevant question is "How much can communication programs change behavior over a specific period of time when basic infrastructure is already in place?" Meta-analyses of U.S. studies have shown average changes of 7 to 10 percentage points (Snyder & Hamilton, 2002).

A meta-analysis of 39 CCP projects concluded "In summary, the greatest effect of the campaigns was on knowledge of family planning methods ($r = .15$)." The symbol " r " represents a standardized measure of the level of effect of communication on knowledge, behavior, and other variables. "There were also positive effects on partners communication ($r = .10$), approval of family planning ($r = .09$), behavioral intentions ($r = .07$), and use ($r = .07$)." The reproductive health behavior results are comparable to results of health campaigns in the U.S. (Snyder et al., 2003). In other words, the behavior of the population in using contraceptives increased by about 7 percentage points after the intervention. Among those exposed to the intervention, it increased by about 12 percentage points.

In an Expert Meeting in 2001 co-sponsored by MEASURE Evaluation and PCS on Evaluating the Impact of Communication Programs, experts from U.S. and international programs offered a number of suggestions, many of which are presented below as are recommendations from the meta-analysis (MEASURE & PCS, 2001).

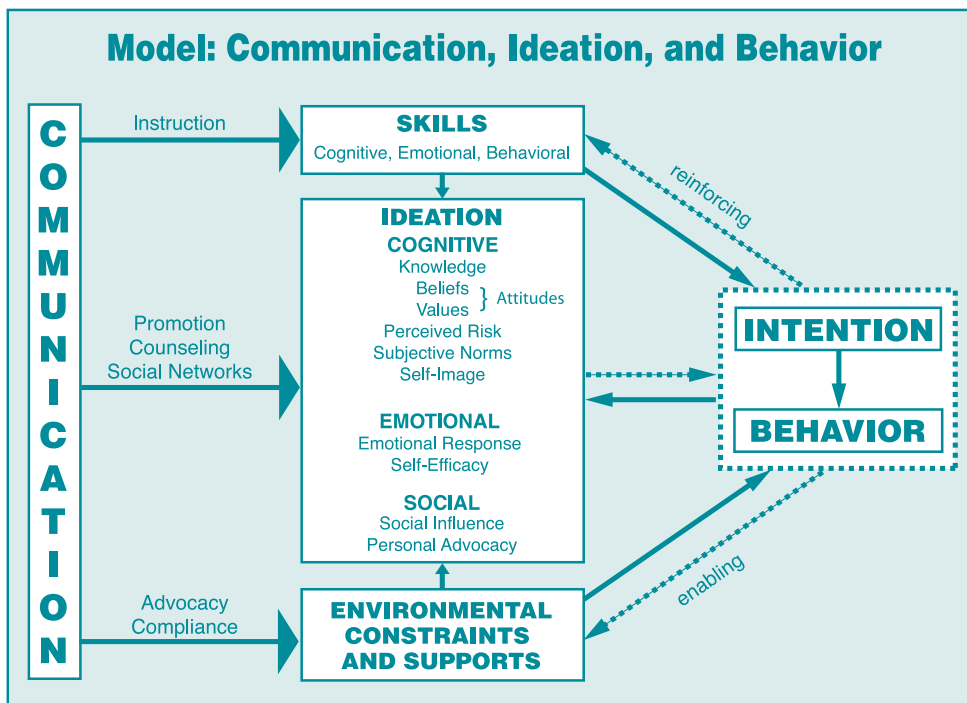
37 Plan for evaluation at the start of any intervention.

To measure change, you need evidence of the situation before your intervention as well as afterwards. To gather this evidence, you need to budget for pre and post intervention data collection and monitoring; to identify trained personnel to collect and analyze data; to define

benchmarks and other intermediate measures; and to establish clear SMART objectives so that you can truly measure whether these objectives were achieved. This planning and baseline data collection should start *before* any activities take place as an integral part of the strategic design of a health communication intervention. For comparability across programs, similar indicators, benchmarks, and questions should be established whenever feasible, as DHS has done.

38 *Use and clearly state a theoretical behavior change model to guide your program.*

Behavior change theories are essentially working models that explain why, how, and through what intermediate steps you think people will change their behavior. They should be explicit in your strategic design. For example, if you believe that social units, such as a small villages in Bangladesh, determine how their residents behave, then your program should be directed toward village leaders and influential men and women within each village (Kincaid, 2000a). Your evaluation should measure not only individual change but also changes among leaders and within the villages as a unit of analysis.



Using ideation theory, PCS developed an index that included communication within community networks and perceptions of existing social norms and majority behavior (Kincaid, 2000a). Using social learning theory, you can evaluate entertainment-

education programs by measuring how much viewers identify with characters and how they may be empowered by the behavior (and the consequences of that behavior) of role models (Kincaid, 2002). Using a social change model and indicators, you can measure how communities move through a process of individual, group, and normative change (Figueroa et al., 2002). Most behavior change theories are stage or step theories that assume behavioral change takes place gradually through a series of intermediate steps, each of which can be defined and measured. When changes in intermediate steps as well as in the final results are consistently in the expected direction, the conclusion that the intervention caused the impact is more convincing.

39 *Use available external resources, especially Demographic and Health Surveys (DHS), which provide comparable cross-sectional data over many years.*

You might encourage DHS to include questions about communication programs, both general and specific, and repeat these questions at regular intervals as was done in Tanzania (RCHS Tanzania, 2000). But you can always use DHS data to provide useful measures of health-related behaviors for a baseline. DHS sample frames and DHS-trained interviewers are also valuable assets for future surveys. The evaluators can then conduct a study to measure changes at follow-up that also include exposure to the program. In Africa, Westoff demonstrated continuing correlations between exposure to mass media, exposure to specific health messages, and desired behavior changes (Westoff & Rodriguez, 1995; Bankole et al., 1993). Repeated cross-sectional surveys, supplemented where possible by longitudinal or panel studies as in Nigeria and other African countries, provide strong evidence not only of correlations between communication programs and behavior but also of a causal connection in that the behavior change consistently followed the intervention (Westoff & Bankole, 1995). Using DHS surveys where possible can save money, assure high quality data, and bring greater credibility to evaluations. But it is a continuing challenge to persuade DHS teams to include questions

about communication when surveys are already long and many new health topics are being added. Start your efforts early, be ready to set priorities, and persist.

40

Develop multiple research designs and data sources to reinforce your conclusions.

Classic experimental designs are not appropriate for large scale or mass media communication programs because random selection is not possible and contamination is unavoidable. But other research designs such as one-group designs with pre-post test, correlation of exposure with behavioral outcomes, and dose-response or “media-intensity” analyses can all be used, preferably in combination. Examples are evaluation reports from Bangladesh (Kincaid, 2000), Ghana (Tweedie et al., 2002), Tanzania (Jato et al., 1999), and Zimbabwe (Kim, et al., 2001a).

Unobtrusive measures or collection of routine data such as clinic records, product sales, or even observation can reinforce survey-based data. In both Nigeria (Piotrow et al., 1990) and Brazil (Kincaid, 1996) records of clinic attendance following mass media promotion provided strong evidence of the impact of mass media promotion. In social marketing programs, such as in Nicaragua and Ghana, increased condom sales testify to the effectiveness of the promotion (Ainslie et al., 2001; Tweedie et al., 2002).

41

Recognize and control for confounding variables such as changes in policy, other programs or promotions, or selective individual exposure.

To be sure the results achieved can be attributed to your campaign rather than something else, you need to identify and quantify the other different factors that might influence behavior. In Tanzania, for example, two radio soap operas, a national Green Star clinic campaign, and a social marketing program were all underway at the same time (RCHS Tanzania, 2000). These reached many of the same people, making it problematic to attribute impact to any one

intervention alone. A dose response analysis suggested that the greater the exposure to any of these messages, the more likely the desired behavior change (Jato et al., 1999).

To take account of selectivity factors that might predispose individuals to be exposed, (e.g. radio or television ownership, rural or urban residence, age, sex, income or education levels, or prior contraceptive use), control for these factors in the final analyses. Propensity indices can also be built in to avoid problems of selectivity or endogeneity (Figueroa et al., 2002). Yet programs and evaluation should not discount the value of persuading those who are predisposed to take further positive action since this audience may be large and may steadily increase as a result of ongoing programs.

42 *Combine qualitative and quantitative methods.*

Use qualitative research effectively not only as formative measures to design interventions and frame survey questions, but also as summative research to explore subtle changes in attitudes and norms. Evaluation of entertainment-education programs, for example, can benefit from in-depth and nuanced attention to audience reactions, emotional responses, specific vocabulary, and even body language of audiences as in research on the Ethiopian serial drama *Journey of Life* (Ferrara et al., 2002).

Similarly, qualitative research in the Near East is providing new insights into precisely how the *Arab Women Speak Out* program affects village women and what personal changes they might make as a result (Underwood et al, 2003). To augment and deepen the findings from the quantitative evaluation of the *Arab Women Speak Out* project, researchers conducted 24 life-story interviews of women who took important steps as a result of their participation in project workshops. The qualitative research allowed women to tell their own stories in their own words, thereby enhancing understanding of the different



A researcher questions a client to gather qualitative data in Peru.

pathways women may take as they seek to empower themselves further. Beneficiaries can also be invited to participate in such qualitative evaluations. In Namibia, for example, in-depth interviews, an environmental audit of services, programs and supplies, and observation of youth behaviors in completing specific tasks are qualitative approaches that are underway. They can also incorporate participation from the community in the evaluation.

Quantitative measures, such as increases in contraceptive prevalence levels and cost-effectiveness, carry weight with donors and expert evaluators. Using comparable indicators in different studies and assessing the anticipated effect size from meta-analyses can aid in setting realistic objectives, in selecting appropriate sample sizes, in contributing to meta-analyses, in tracking changes in program impact over time, and in comparing the impact of different programs or interventions. Where qualitative and quantitative research can be combined, your evaluations will gain credibility.

43

Design evaluations not only to measure impact but also to improve future programs.

A good evaluation can do more than just show whether communication programs influenced behavior. It can and should indicate what particular messages, channels, activities, or approaches worked best, why they worked, and how they might be improved in future programs. The findings of the first-ever male motivation campaign in Zimbabwe demonstrate a program evaluation that contributed directly to improved follow-on programs (Piotrow et al., 1992). Analysis showed after the campaign men said they were interested in family planning and wanted to play a larger role but many also said they wanted to be the prime decision-makers rather than sharing decision-making with their wives. As a result, follow-on campaigns put much more emphasis on the need for spouses to talk to one another and to share decision-making, with men as partners in the process.

Chapter Seven

SHARE RESULTS AND CREDIT



- 44 Keep donors, officials, program staff, and participants informed on a continuing basis of activities, research, and evaluation of results in brief, non-technical reports.
- 45 Schedule a press conference or briefing to provide a comprehensive overview of your project when evaluation results are available.
- 46 Prepare and distribute working papers, field reports, specialized newsletters, and summaries as well as peer-reviewed articles.
- 47 Do not claim more impact than you can demonstrate.
- 48 Use information technology to disseminate program results.

It is not enough to evaluate communication projects if results and credit for those results are not shared with important audiences. These include:

- ▶ *Participants in the program*
- ▶ *Sponsors, donors, and government officials*
- ▶ *The media and public, and*
- ▶ *Experts in the field*

All are important. Participants want to know that their actions made a difference. Team members and supporters want to receive credit for their efforts and all donors and governments need to know how a program worked in order to decide on future support. The media and the public reached by the media are entitled to know what is happening in their own areas and with what results. Experts in the field will want to examine what communication interventions worked and how they might advance the state of knowledge in a communication study.

44

Keep donors, officials, program staff, and participants informed on a continuing basis of activities, research, and evaluation of results in brief, non-technical reports.

Sponsors, donors, and policymakers do not want to be surprised so share both good and bad news with them as a program progresses. Reports to governments and donors should be timely, concise, clear, and organized around the priorities of those audiences. They should give credit to all participants. These preliminary reports, usually not published, should convey critical findings of surveys and other research.

Whether as audiences, analysts or respondents, participants in the program and evaluation process also want to know the results of the research to which they contributed. Researchers together with program and field staff should write short, user-friendly summaries of the findings with a view to how the findings can be used in future program design. Teach program staff how to interpret the data so they can use it in other programs. Encourage program staff to hold community-level dissemination seminars.

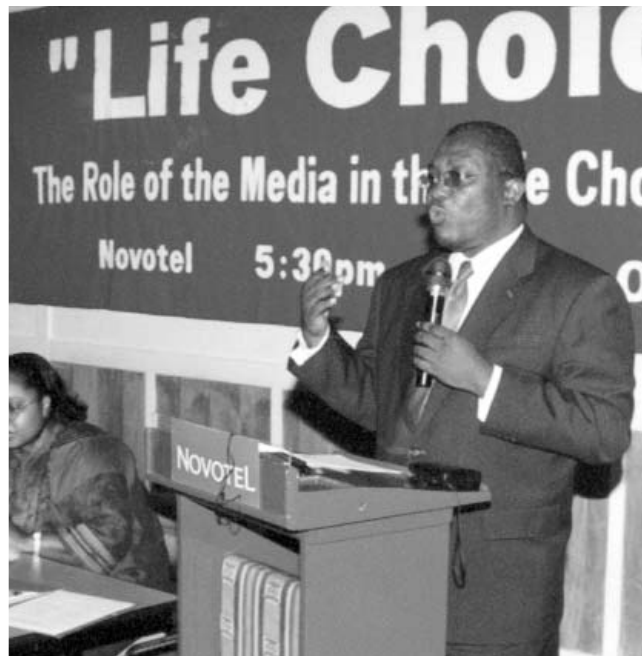


The MEASURE project disseminated a report on the summary of highlights at the Belmont conference.

45 *Schedule a press conference or briefing to provide a comprehensive overview of your project when evaluation results are available.*

You should encourage local partners to arrange a well-publicized media briefing or panel discussion to review major program results. These briefings often become front-page news. One recent example is the September 2002 press briefing in Addis Abba, Ethiopia, when PCS staff released evaluation data on the serial drama *Journey of Life*. From Bangladesh and Nepal to Ghana and Bolivia, such briefings attracted great media interest. They also kept large audiences informed

Press briefing by the Life Choices campaign in Ghana.



about important health issues. Donors and government officials as well as all partners and team members should be included in these presentations and should be generously credited for their participation. Frequently, offering to write a brief speech for a minister at such an event becomes a valuable opportunity to inform him or her more fully and win continuing public support.

46 *Prepare and distribute working papers, field reports, specialized newsletters, and summaries as well as peer-reviewed articles.*

Peer-reviewed articles, like experimental design studies, serve many purposes. They provide evidence that is judged acceptable by the scientific community; they provide accessible and lasting documentation of effective programs in credible sources; they bring visibility and prestige to the program; they reach academic

The two-page *Communication Impact!* newsletter offers a brief description, key data, and illustrations in a manner designed to catch the attention of busy, higher level officials. Specialized newsletters, such as the *Mobilizer* prepared by PCS and Save the Children and the Quality Working Group newsletter, are helpful to persons working in the specific fields of community mobilization and quality care.



47 ***Do not claim more impact than you can demonstrate.***

Since successful health communication programs usually depend on a solid infrastructure and adequate supplies, communication programs need to measure the net change caused by communication after taking account of other factors. This might mean subtracting for the secular long-term trends, controlling for selective exposure by special segments of the population, and giving credit to any other ongoing promotions. An evaluation of a Philippine media campaign in 2000-2001 showed a net effect that was about half the crude increase in contraceptive prevalence but still considerable – a net adjusted increase in modern contraceptive use of 3.6 percent or 196,141 new adopters of modern contraceptive methods after taking account of other factors. Cost effectiveness was calculated at \$2.79 per new acceptor of a modern method (Kincaid & Do, 2003).

48 ***Use information technology to disseminate program results.***

There are many ways to share information about program results, ranging from news programs and articles in traditional mass media such as newspapers, radio, and television to the latest Internet technology. Put evaluation results on your own website, include authoritative reports (published or not) in POPLINE, encourage counterpart organizations to establish websites that cover local events and evaluations, send abstracts to the Communication Initiative's *Drumbeat*, use electronic journals, and include data on CDs covering appropriate countries or issues. For example, in addition to regular printed issues of *Communication Impact* (16 issues to date), text and summaries of each issue are included on the website of the Center for Communication Programs.

Chapter Eight



BUILD CAPACITY AND SUSTAINABILITY

- 49 Build or strengthen the capacity of institutions in-country to carry out health communication programs.
- 50 Support ongoing individual and institutional training programs with strong in-country units and access to high-level international training.
- 51 Generate funds directly for local projects or organizations as soon as possible.
- 52 Maintain close links with counterparts and partners even after formal relationships have ended.

Since the long-term goal of development is to enable host-country institutions and programs to achieve essential results with little or no outside help, all cooperating agencies should plan for continuity. That means developing a long-term strategy to get out gracefully by strengthening capacity and long-term sustainability. The core of such an exit strategy is building local capacity with trained individuals working in a supportive environment for competent, committed organizations with enough local clout, coverage, and continuity to sustain programs and accomplish their objectives.

49 Build or strengthen the capacity of institutions in-country to carry out health communication programs.

For effective capacity building, either strengthen the skills and resources of existing organizations or establish new ones or both. Ideally, both government ministries of health and active NGOs should all have a basic communication capability, but in practice this may not be the case. Thus rather than encourage less well-equipped organizations to take on tasks they will not excel at, you may create a separate organization with strong communication skills that can work with the government and other NGOs. In Bangladesh, for example, the Bangladesh Center for Communication Programs was established in 1997 with staff who had formerly been part of the PCS office under an expatriate country representative. Over more than a decade, the office was transformed into a skilled Bangladeshi organization with well-trained communication staff, a high-level Bangladeshi board of directors, a long-term business plan, and multiple sources of revenue. CCP provides technical assistance only as requested.

Similarly in Bolivia, the Bolivia Center for Communication Programs is a spin-off from the PCS country office. While it had less time to develop the necessary management and business skills and less access to PCS technical skills because of budget constraints, the Bolivia CCP is a going concern, offering high quality communication support to the government of Bolivia and NGOs. Comparable NGOs are being established in Uganda, Zambia, and the Philippines.

Generally, such transformations work best when the shift can be gradual, fully supported by donors, and open to continuing expert technical assistance as needed.

PCS also greatly strengthened capacity and added technical health communication expertise to such government agencies as Egypt's State Information Service, the Office of Health Education in Ghana's Ministry of Health, Tanzania's Ministry of Health, and Jordan's National Population Commission. And many NGOs—such as the Turkish Family Health and Planning Foundation, the Planned Parenthood Federation of Nigeria, the Family Planning Association of Kenya, and the Centre for African Family Studies—increased their understanding of communication strategy and their ability to mount programs.

50 *Support ongoing individual and institutional training programs with strong in-country units and access to high-level international training.*

Learning never ends. The communication field is especially dynamic and responsive to innovations. Thus, training in communication skills is not a one-time task but needs to continue to reach individuals and institutions in all parts of a country; to influence different types of agencies, from ministries and NGOs to advertising agencies; to spread new skills and technologies as they develop; and to teach new cohorts of communication professionals. This includes educational degree programs as well as short-term workshops and seminars and should increasingly involve universities and professional schools for teachers, health personnel, and communication experts.



The SCOPE training software was adapted for use in over 20 countries and six languages.

For short-term training and program planning, the SCOPE training software was adapted for use in over 20 countries and six languages (English, French, Spanish, Russian, Arabic, and Vietnamese). As mentioned in Lesson 9, it is used for international training in the U.S., Indonesia, Bangladesh, the Philippines, and the Arab world; for HIV/AIDS programs in Haiti, Nigeria, and Madagascar; and for regional and district level planning in Indonesia and Zambia. With more and more in-country trainers and adaptations

and increasing emphasis on decentralized health programs, this training needs to continue, even after other elements of technical assistance may diminish or end.

51 ***Generate funds directly for local projects or organizations as soon as possible.***

Sustainability means the ability to generate support from multiple donors or sources for ongoing activities without U.S. agencies. This can be accomplished by seeking help directly from other donors or from commercial sources. In Kenya, direct contributions from commercial donors and UNFPA to the Family Planning Association of Kenya kept the popular and high-impact Youth Radio Variety Show on the air. PCS and USAID missions together served as fundraisers and promoters for Ecuador's *Arcandina* animated television show on population and the environment, for the Bangladesh Center for Communication Programs (BCCP), and for the Bolivia Center for Communication Programs, among others. In Bangladesh, USAID encouraged the Japanese government to contribute directly to BCCP to purchase 56,000 green umbrellas for field workers under the Green Umbrella campaign to promote integrated health services. Worldwide, major donors have included radio and television channels; large international firms such as Lever Brothers, Aromatic Cosmetics, Avon, Vodacom, Universal Music, Bom Preco Super Markets, Pepsi Cola, Coca-Cola; airlines; banks; electronics firms; magazines; and advertising agencies.

Program staff generated some funds as a result of active solicitation to secure significantly reduced rates for TV and air time from private government stations, reduced rates from advertising agencies as a result of large-scale campaigns, and contributions or collateral materials from multinational corporations. In Indonesia, the Healthy Indonesia 2010 Coalition leveraged \$800,000 in two years of operation from such entities as Unilever, Avon, Indofood, Royal Dutch Shell, the Rotary Club, television stations, the Asian Development Bank, the World Bank, and local governments. Commercial firms see



In Kenya, direct contributions from commercial donors and UNFPA to the Family Planning Association of Kenya kept the popular and high-impact Youth Radio Variety Show on the air.

the advantages of being associated with certain health promotion activities, particularly those on radio and television that can attract large mass audiences.

Entertainment-education programs can be a major source of leveraged funds because commercial firms will often compete with one another to sponsor popular media shows. In Bangladesh, for example, a serial drama series oriented around village health workers and clinics generated more than \$50,000 for the Bangladesh CCP, which covered all airtime costs and subsidized some production costs.

Since commercial contributions are usually decided in-country by local firms or local branches of multinational corporations, it is important to learn about local products, sales, markets, consumer preferences, and business donation policies. Recommendations from international headquarters may be helpful, but good local relationships are most important.

52

Maintain close links with counterparts and partners even after formal relationships have ended.

Personal contacts make a difference. Host-country nationals value their relationship with U.S. colleagues and institutions and with one another. Just because a specific funding channel has dried up or a contract ended, your interest in and support for colleagues overseas should not melt away. Keep in touch with former counterparts by e-mail, send them useful materials from time to time, and counsel and advise them whenever possible. Encourage South-South links through professional meetings, conferences, and consultancies. By your continuing actions, show former colleagues and partners that your interest in their work and the health of their country was not limited to the time frame of a project and that you have an ongoing interest in their progress.

It may be easier for a large institution like a university to maintain such connections, but all those who work within international programs should make clear that these are not on-off relationships but rather a genuine concern to maintain personal and professional links and to support, help, and learn from one another.

CONCLUSION

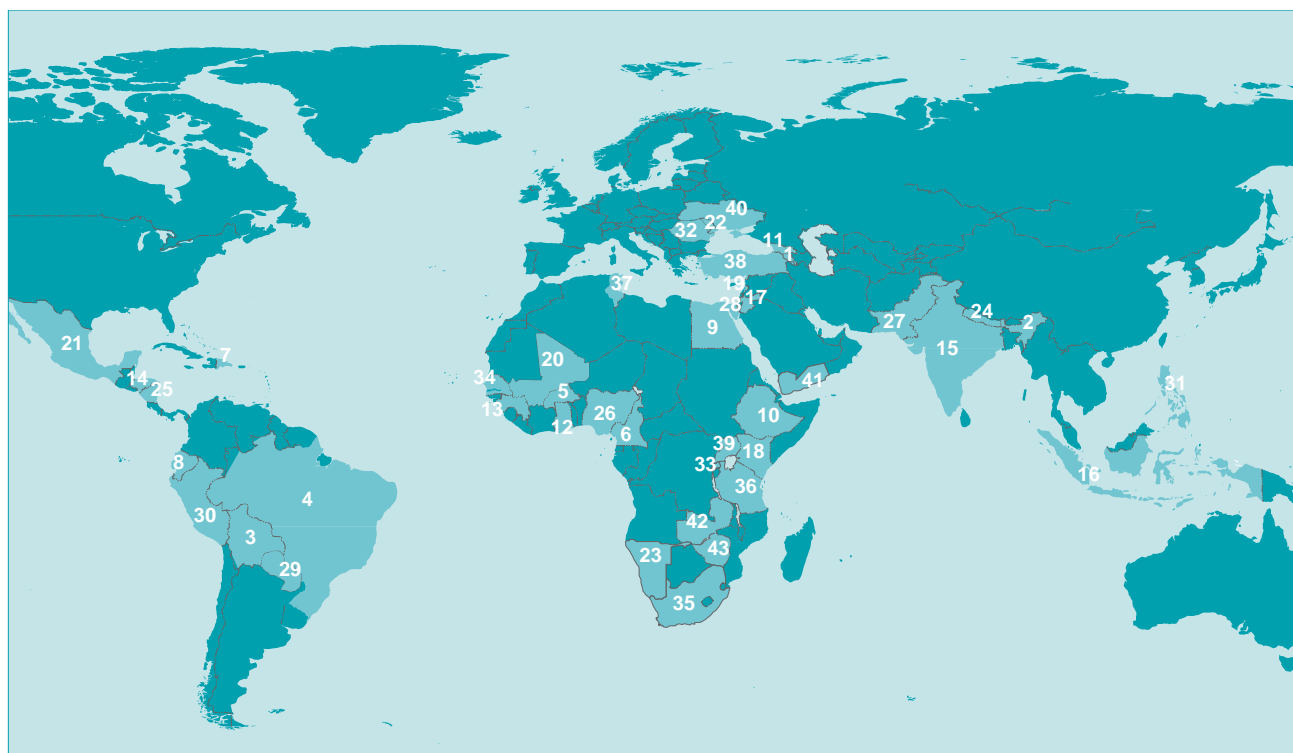
The PCS experience over the past 20 years contributed to a much more strategic understanding of the role communication plays in public health. Communication is no longer viewed as a product, a poster, or a pamphlet. Communication professionals are no longer called in to help save a faltering program but are now often integral participants in the design and strategic positioning of new programs. Moreover, the deliberate inclusion of managers, directors, policymakers, government officials, and donors in the PCS-supported training and mentoring programs worldwide helped break the cycle of communicators only talking to communicators. It also fostered high-level appreciation of the use of strategic communication in major programs.

As programs in the field increasingly move toward integration across health issues (e.g., family planning and reproductive health, HIV/AIDS, child survival, maternal health, nutrition, and infectious disease) and sometimes across health and democracy and governance, the last five years of PCS4 have been particularly challenging and exciting. Programs developed in those final years showed how to apply the basic principles of communication to different health concerns vertically and horizontally while recognizing that each program needed its own unique, evidence-based, creative approach.

Indeed, the PCS experience is the collective experience of several thousand local organizations and health practitioners and the millions of people reached worldwide. That experience is now an integral part of the field of health communication knowledge and practice.

PCS ACTIVITIES IN 42 COUNTRIES

Where PCS Worked (1982-2003)



- | | | |
|----------------------|---------------------|-------------------|
| 1 Armenia | 16 Indonesia | 30 Peru |
| 2 Bangladesh | 17 Jordan (AWSO) | 31 Philippines |
| 3 Bolivia | 18 Kenya | 32 Romania |
| 4 Brazil | 19 Lebanon (AWSO) | 33 Rwanda |
| 5 Burkina Faso | 20 Mali | 34 Senegal (CUP) |
| 6 Cameroon (CUP) | 21 Mexico | 35 South Africa |
| 7 Dominican Republic | 22 Moldova | 36 Tanzania |
| 8 Ecuador | 23 Namibia | 37 Tunisia (AWSO) |
| 9 Egypt | 24 Nepal | 38 Turkey |
| 10 Ethiopia | 25 Nicaragua | 39 Uganda (CUP) |
| 11 Georgia | 26 Nigeria | 40 Ukraine |
| 12 Ghana | 27 Pakistan | 41 Yemen (AWSO) |
| 13 Guinea (CUP) | 28 Palestine (AWSO) | 42 Zambia |
| 14 Honduras | 29 Paraguay | 43 Zimbabwe |
| 15 India | | |

SELECTED AWARDS AND CITATIONS [1996-2002]

*Presented to the Johns Hopkins Bloomberg School of Public Health/
Center for Communication Programs and the PCS4 Project*

2002

ISHI Youth HIV/AIDS campaign (Tanzania): [United Nations Award](#) for campaigns exemplifying the goals and ideals of the United Nations.

ISHI Youth HIV/AIDS campaign (Tanzania): 2002 [International Public Relations Golden World Awards for Excellence](#) for creative and innovative campaigns.

Adolescent Premarital Sexual Behavior in Nicaragua: Explaining the Gender Differences (poster): The Population Association of America's [Blue Ribbon Award](#).

Arab Women Speak Out (Near East region): The 2002 [Gold Quill Award](#) in the category of "economic, social and environmental development/third-world development" from the International Association of Business Communicators (IABC).

2001

Arcandina (The Andean Ark) (Ecuador): The National Wildlife Federation (NWF) named the children's television show the [Best International Environmental Program](#) of 2001.

2000

Sentrong Sigla Movement (Center of Vitality) (The Philippines): [The 2000 Global Media Award, Country Award, the Population Institute](#).

1999

Men's Participation Campaign (Jordan): HRH Princess Basma on behalf of the Jordan National Population Commission presented PCS with an [award for excellent achievement](#).

1998

PCS (Jordan): HRH Princess Basma on behalf of the National Population Commission presented the [award for outstanding contribution](#) to the Jordanian population program.

Time for Love (Bolivia) and **Moon Skin** (Peru): The two TV mini-series co-produced by PCS shared [first place](#) in the 4th Latin American Festival of Video Directed by Women in Bogota, Colombia.

RH is in Your Hands Campaign (Bolivia): [Chris Award honorable mention](#).

Planning is a Matter of Caring (Mexico): [Chris Award Bronze Plaque](#) for the mass media campaign.

Speaking with Confidence (Latin America): [Chris Award honorable mention](#) for the training video

Together We Decide When (Nicaragua): [Chris Award honorable mention](#) for the television spot.

1997

The Guiding Light Radio Spot (Indonesia): a [Joey Award Trophy](#) from the San Jose Film and Video Commission for the radio spot co-produced by PCS and BKKBN.

Trendsetters newsletter (Zambia): The Population Institute's [XVIIIth Annual Global Media Award](#) in the category of Excellence in Population Reporting.

The Women's Campaign (Ecuador): [Honorable mention](#) at the IPPF/Western Hemisphere Region's [Rosa Cisneros Award Ceremony](#) for the service promotion campaign developed by NGO APROFE, with technical assistance from PCS.

"Client Communication and the Quality of Family Planning Counseling: Interaction Analysis in Kenya," a paper by PCS staff Young Mi Kim, Dan Odallo, Adrienne Kols and Margaret Thuo: [Award for one top three papers](#) presented in the Health Communication Division at the Montreal Annual Meeting of the International Communication Association.

1996

Hablemos En Pareja (Bolivia): the [Silver Apple Award](#) from the National Educational Media Network, as part of the annual conference and market, CONTENT '96.

Alang Alang (Indonesia): [Finalist](#) in the 1996 National Council for International Health Film Festival.

Las Manitos Reproductive Health Campaign (Bolivia): The Population Institute's XVIIIth [Annual Global Media Award](#) in the category of Best Commercial Advertising Campaign, co-produced by PCS and the Bolivia National Reproductive Health Campaign.

REFERENCES

- Aguilar, M. (2002). Arcandina: Beyond Television to Advocacy, Capacity Building, and Community Mobilization. (Unpublished report.) Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Aguilar, M. (December 1998). Isabel: Your Electronic Counselor makes sex education accessible to young people in Peru. (Unpublished report). Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Ainslie, R., & Gurdian, M. (November 2001). Nicaraguan Youth Begin To Play It Safe. *Communication Impact!* No. 12. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Ainslie, R., & Said, R.V.A. (2000). PROQUALI Improves Health Services in Brazil. *Communication Impact!* No. 10. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Andreasen, A.R. (1995). Marketing Social Change: Changing Behavior to Promote Health, Social Development, and the Environment. San Francisco: Jossey-Bass.
- Awusum D., Sienché C., & Obwaka E. (2001). Break the Silence: Talk About AIDS. *Special Publication*, No. 20. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Babalola, S., Kiragu, K., Ajiboye, J.K.T., & Chidi, I. (2000). Women's Empowerment Gains in Nigeria. *Communication Impact!* No. 8. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Babalola, S., Kiragu, K., Sagui, C.M., Ajiboye, J.K.T, & Chidi, I. (1999). Building Partnerships in Governance: Nigeria Democracy and Governance Project (Evaluation Report, Phase I), *Field Report* No. 11, Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Bankole, A., Rodriguez, G., & Westoff, C.F., (1993). The Mass Media and Reproductive Behavior in Nigeria. Paper Presented at the annual meeting of the Population Association of America, Cincinnati, April 1-3.
- Boulay, M., Storey, J.D., & Sood, S. (2002). Indirect exposure to a family planning mass media campaign in Nepal. *Journal of Health Communication*. 7(5): 379-399.
- de Fossard, E. (1998). How to design and produce radio serial drama for social development: A program manager's guide. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- de Fossard, E. (1996). How to write a radio serial drama for social development: A script writer's manual. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Do, M. P., & Kincaid, D.L. (2001). Impact of the *Shabuj Chhaya* television drama in Bangladesh: Key findings. A working paper. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- El Shaffie, M., Brancich, C.D., El Gebaly, H., Kols, A., Boulay, M., Lewis, G., Saffitz, G., & Hess, R. (2000). Taking Quality Nationwide: Egypt's Gold Star Quality Family Planning Clinics. (Unpublished report). Cairo: Ministry of Health and Population. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Ferrara, M., Witte, K., & Jerato, K. (2002). *A Case Study of Journey of Life: A process evaluation of a radio serial drama*. (Unpublished report). Addis Ababa: Ethiopian National Office of Population. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.

- Figueroa, M. E., Kincaid, D. L., Rani, M., & Lewis, G. (2002). *Communication for social change: A framework for measuring the process and its outcomes*. New York: The Rockefeller Foundation. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Figueroa, M.E., Bertrand, J.T., & Kincaid, D. L. (2002). *Evaluating the Impact of Communication Programs. Summary of an Expert Meeting*. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs. Chapel Hill, NC: The MEASURE Evaluation Project.
- Greenberg, R.H., Williams, J.R., Saffitz, G.B., Yonkier, J.B., & Rimmon, II, J.G. (1996). *How to Select and Work with an Advertising Agency, Handbook for Population and Health Communication Programs*. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Gumucio Dagron, A. (2001). *Making Waves: Stories of Participatory Communication for Social Change*. New York: The Rockefeller Foundation.
- Hasan, K. (2001). *Shabuj Chhaya audience evaluation survey 2000* (Unpublished Report). Dhaka, Bangladesh: ORG-MARG QUEST, Social Research Division.
- Heerey, M., Merritt, A.P., & Kols, A.J., (2003). *Improving the Quality of Care. Quality Improvement Projects from Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs. Center Publication*. No. 101. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Heerey, M., Amoa, M., Chalk, G., Beisser, M., & Kols, A. (2003). *Client-Provider Communication: Successful Approaches and Tools* [CD-ROM]. Baltimore, Quality Associates, Inc. & Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Hornik, R. (2002). *Public health communication: Evidence for behavior change*. Mahway, NJ: Lawrence Erlbaum Associates.
- Howard-Grabman, L., & Snetro, G. (2003) *How to Mobilize Communities for Health and Social Change*. Baltimore: *Field Guide*. Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Howard-Grabman, L., Ainslie, R., & Aguilar, M. (2001). *Building Bridges for Quality: A Community Mobilization Project to Improve Quality*. (Unpublished report). Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Howlader, S.R. & Chakma, P.B. (1997). *Impact of Observation Study Tours in Indonesia on Activities and Performances of Family Planning Programs in Bangladesh : An Evaluation*. (Unpublished report). Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Jato M.N., Simbakalia C., Tarasevich J.M., Awasum D.N., Kihinga C.N., & Ngirwamungu E. (1999). The impact of multimedia family planning promotion on the contraceptive behavior of women in Tanzania. *International Family Planning Perspectives*. 25(2):60-7.
- Kim, Y.M., Kols, A., Mwargo, P., & Awasum, D. (2000). Differences in counseling men and women: family planning in Kenya. *Patient Education and Counseling*. 39(1):37-47.
- Kim, Y.M., Putjuk, F., Basuki, E., & Kols, A. (2000). Self-assessment and peer review: improving Indonesian service providers' communication with clients. *International Family Planning Perspectives*. 26(1):4-12.
- Kim, Y.M., Kols, A., Nyakauru, R., Marangwanda, C., & Chibatamoto, P. (2001). Promoting sexual responsibility among young people in Zimbabwe. *International Family Planning Perspectives*. 27(1):11-19.
- Kim, Y.M., Kols, A., Bonnin, C., Richardson, P., & Roter, D. (2001). Client communication behaviors with health care providers in Indonesia. *Patient Education and Counseling*. 45(1):59-68.
- Kincaid, D. L., & Do, M. P. (2003). Causal attribution and cost-effectiveness of a national communication campaign: Family planning promotion in the Philippines. *A working paper*. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Kincaid, D.L. (2002). Drama, emotion, and cultural convergence. *Communication Theory*. 12(2):136-152.

- Kincaid, D.L. (2000). Social networks, ideation, and contraceptive behavior in Bangladesh: A longitudinal analysis. *Social Science & Medicine*. 50(2):215-31.
- Kincaid, D.L., Merritt, A.P., Nickerson, L., Buffington, S.D., de Castro, M.P., & de Castro, B.M. (1996). Impact of a mass media vasectomy promotion campaign in Brazil. *International Family Planning Perspectives*. 22(4):169-75.
- Kincaid, D.L., Yun, S.H., Piotrow, P.T., & Yaser, Y. (1992). Turkey's mass media family planning campaign. In T. E. Backer & E.M. Rogers (Eds.), *Organizational aspects of health communication campaigns: What works?* Newbury Park, CA: Sage.
- Kiragu, K., Obwaka, E., Odallo, D., & Van Hulzen, C. (1996). Communicating about sex: adolescents and parents in Kenya. *AIDS/STD Health Promotion Exchange*. 3:11-3.
- Krenn, S., Kiragu, K., Odallo, D., & Sienché, C. (1998). Advocacy and Mass Media: Winning Combination for Kenyan Youth. *Communication Impact!* No. 2. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Lettenmaier, C., & Kiragu, K. (1999). Uganda Communication Campaigns Spur Integrated Health Programs. *Communication Impact!* No. 6. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Lettenmaier, C., & Gallen, M. (1997). Why Counseling Counts! *Population Reports*. Series J. No. 36. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Lynam, P.F., Dwyer, J.C., Bradley, J. (1994). Inreach: reaching potential family planning clients within health institutions. AVSC Working Paper No. 5. New York: Association for Voluntary Surgical Contraception.
- McKenzie, S., Rimon, J., & Saffitz, G. (1999). *New Directions: Proposal and Concept for a New NGO in the Philippines*. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- O'Sullivan, G.A., Yonkier, J.A., Morgan, W., & Merritt, A.P. (2003). *A Field Guide to Designing a Health Communication Strategy*, Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Piotrow, P.T., & de Fossard, E. (2003). Entertainment-Education as a Public Health Intervention. *Entertainment-Education and Social Change: History, Research, and Practice*. Singhal, A., Cody, M., Rogers, E., & Sabido, M. (Eds). Mahway, NJ: M. Lawrence E. Baum, Inc.
- Piotrow, P.T., Rimon, J.G. II, Winnard, K., Kincaid, D.L., Huntington, D., & Convisser, J. (1990). Mass media family planning promotion in three Nigerian cities. *Studies in Family Planning*. 21(5):265-74.
- Rimon, J.G. II, Lediard, M., MacLaren, L., Saffitz, G.B. (2003). Koalisi Untuk Indonesia Sehat - KUIS (Healthy Indonesia Coalition) Redesign Team Report, Population Communication Services. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Rimon, J.G. II. (November 2001). Behavior Change Communication in Public Health: Beyond Dialogue Moving Toward Convergence. Presented at the UN Roundtable on Development Communication, Managua, Nicaragua. Sponsored by UNFPA and the Panos Institute.
- Rimon, J.G. II, & de la Rosa, M. (1998). Philippines Communication Outreach Accelerates Family Planning Use in 1993-1996. *Communication Impact!* No. 3. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Rimon, J.G. II, Treiman, K.A., Kincaid, D.L., Silayan-Go, A., Camacho-Reyes, M.S., Abejuela, R.M., & Coleman, P.L. (1994). Promoting Sexual Responsibility in the Philippines through Music: An Enter-Educate Approach. *Occasional Paper Series*. No. 3. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Robey, B., Thomas, E., Baro, S., Kone, S., & Kpakpo, G. (1998). Men: Key Partners in Reproductive Health, A Report on the First Conference of French-Speaking African Countries on Men's Participation in Reproductive Health. *Special Publication*. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.

- Rogers, E.M. (1973). *Communication Strategies for Family Planning*. New York: Free Press. 451 pgs.
- Saba, W. (1997). Forging Partnerships for Health in Latin America: Factors Influencing the Success of Interagencies Committees. Presentation at the American Public Health Association's 125th Annual Meeting, Indianapolis, IN.
- Singhal, A., & Rogers, E. (2003). Lessons Learned from Entertainment-Education. *Entertainment-Education and Social Change: History, Research, and Practice*. Singhal, A., Cody, M, Rogers, E, & Sabido, M. (Eds). Mahway, NJ: Lawrence E. Baum, Inc.
- Singhal, A., & Rogers, E. (1999). *Entertainment-Education: A Communication Strategy for Social Change*. Mahwah, N.J.: Lawrence Erlbaum Associates.
- Snyder, L.B., Diop-Sidibé, N., & Badiane, L. A (2003). Meta-Analysis of the Impact of Family Planning Campaigns Conducted by the Johns Hopkins Bloomberg School of Public Health / Center for Communication Programs. Presented at the International Communication Association annual meeting, San Diego: May 2003.
- Snyder, L.B., & Hamilton, M.A. (2002). "Meta-Analysis of U.S. Health Campaign Effects on Behavior: Emphasize Enforcement, Exposure, and New Information, and Beware the Secular Trend." In R. Hornik (Ed.) *Public Health Communication: Evidence for Behavior Change* pp. 357-383. Hillsdale, NJ: Lawrence Erlbaum Associates.
- Storey J.D. & Jacobson, T. (July 2002) Development Communication and Participation: Applying Habermas to a Case Study of Population Programs in Nepal. Presented at the 52nd Annual Conference of the International Communication Association, Seoul, Korea
- Storey, J.D., Boulay, M., Karki, Y., Heckert, K., & Karmacharya, D.M. (1999). Impact of the integrated radio communication project in Nepal, 1994-1997. *Journal of Health Communication*. 4(4):271-94.
- Stratten, K., & Ainslie, R. (2003). A Field Guide for Organizations: How to Set Up a Hotline. *Field Guide* 101. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Tweedie, I., Boulay, M., Fiagbey, E., Banful, A., & Lokko, K. (2002). Ghana's Stop AIDS Love Life Program Phase 1: Evaluation Report February 2000 - June 2001. Accra: Ghana Social Marketing Foundation. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Tweedie, I., Glover, E.K., Bannerman, A., Nerquaye-Tetteh, J., & Arkhurst, S. (1997). Context and content of condom and abstinence: Negotiation among youth in Ghana. Report on Qualitative Research. Ghana: Planned Parenthood Association of Ghana. University of Ghana, Legon/School of Performing Arts. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Underwood, C., & Jabre, B. (2003). "Arab Women Speak Out: Strategies for Self-Empowerment" in *Video Power: Images that Transform and Empower*. Shirley White. (Ed). Sage Publications, Inc.
- Underwood, C., & Jabre, B. (2001). AWSO Project Helps Arab Women Redirect Their Lives. *Communication Impact!* No. 13. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Underwood, C.R. (2000). Islamic precepts and family planning: The perceptions of Jordanian religious leaders and their constituents. *International Family Planning Perspectives*. 26(3):110-117 & 136.
- Valente, T.W. "Evaluating Communication Campaigns." (2001). Chapter 6. *Public Communication Campaigns*. Third Edition. Ronald E. Rice and Charles K. Atkin. (Eds). Sage Publications, Inc.
- Valente, T.W., Poppe, P.R., & Merritt, A.P. (1996). Mass-media-generated interpersonal communication as sources of information about family planning. *Journal of Health Communication*. 1(3):247-65.
- Westoff, C. F., & Bankole, A. (1995). Unmet Need: 1990-1994. *Demographic and Health Surveys Comparative Studies*. No. 16. Calverton, MD: Macro International, Inc.

- Whitney, E., Shahjahan, M., Kincaid, D.L., & de Fossard, E. (1999). Bangladesh Television Drama Promotes Integrated Services. *Communication Impact!* No. 7. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Zaman, F., & Underwood, C. (2003). The gender guide for health communication programs. Center Publication No. 102. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.

PUBLICATIONS & REPORTS *Produced under PCS*

- (2002). HIV/AIDS Program Collaboration. *Special Publication*, No. 25. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- (2000). *Tanzania Reproductive and Child Health Survey 1999*. Calverton, Maryland: National Bureau of Statistics and Macro International Inc.
- (1999). “A” Frame for Advocacy. *Special Publication*, No. 13. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- (1998). Strategic Communication: Making a Difference. *Special Publication*, No. 12. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- (1997). The P Process, Process and Principals of Strategic Communication for Health. *Special Publication*, No. 5. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- (1994). The Use of Mainstream Media to Encourage Social Responsibility: The International Experience. Washington, D.C.: Advocates for Youth. Menlo Park, CA: The Henry J. Kaiser Family Foundation.
- Aguilar, M. (2002). Arcandina: Beyond Television to Advocacy, Capacity Building, and Community Mobilization. (Unpublished report.) Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Aguilar, M. (December 1998). Isabel: Your Electronic Counselor makes sex education accessible to young people in Peru. (Unpublished report). Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Ainslie, R., & Gurdian, M. (November 2001). Nicaraguan Youth Begin To Play It Safe. *Communication Impact!* No. 12. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Ainslie, R., & Said, R.V.A. (2000). PROQUALI Improves Health Services in Brazil. *Communication Impact!* No. 10. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Awasum D., Sienché C., & Obwaka E. (2001). Break the Silence: Talk About AIDS. *Special Publication*, No. 20. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Babalola S., Awasum D., & Quenum-Renaud B. (2002). The correlates of safe sex practices among Rwandan youth: A positive deviance approach. *African Journal of AIDS Research*. 1(1): 13-23.
- Babalola S., Sakolsky N., Vondrasek C., Moulom D., Brown J., & Tchupo J.P. (2001). The impact of a community mobilization project on health-related knowledge and practices in Cameroon. *Journal of Community Health*. 26(6):459-477.
- Babalola S., Vondrasek C., Brown J., & Traoré R. (2001). The impact of a regional family planning service promotion initiative in Sub-Saharan Africa: evidence from Cameroon. *International Family Planning Perspectives*. 27(4):186-93 & 216.
- Babalola, S., & Vondrasek, C. (2001). Community Participation is Key to Supporting Quality in Gold Circle Clinics. *Communication Impact!* No. 11. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Babalola, S., Kiragu, K., Ajiboye, J.K.T., & Chidi, I. (2000). Women’s Empowerment Gains in Nigeria. *Communication Impact!* No. 8. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.

- Babalola, S., Kiragu, K., Sagui, C.M., Ajiboye, J.K.T., & Chidi, I. (1999). Building Partnerships in Governance: Nigeria Democracy and Governance Project (Evaluation Report, Phase I), *Field Report* No. 11, Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Boulay, M., Storey, J.D., & Sood, S. (2002). Indirect exposure to a family planning mass media campaign in Nepal. *Journal of Health Communication*. 7(5): 379-399.
- Boulay M., & Valente T.W. (1999). The relationship of social affiliation and interpersonal discussion to family planning knowledge, attitudes and practice. *International Family Planning Perspectives*. 25(3):112-8 & 138.
- Bouman, M.A., Coleman, P., Cambridge, V.C. (2001). The Third International Entertainment Education Conference for Social Change. *Special Publication*, No. 21. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Bhushan, I. (November 1997). Understanding Unmet Need. *Working Paper*. No. 4. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Brancich, C.D., Hess, R, El Shaffie, M, El Gebaly, H, & Underwood, C. (1998). Egypt's Gold Star Quality Program Wins Clients and Communities. *Communication Impact!* No. 4. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Coleman, P.L. (June 2000). The Enter-Educate Approach for Promoting Social Change. *Journal of Development Communication*. 11(1):75-81.
- Coleman, P.L., Palmer, A., & Bharath, U. (1998). A Report on the Second Annual Conference on Entertainment-Education and Social Change. *Special Publication*, No. 9. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- de Fossard, E. (1998). How to design and produce radio serial drama for social development: A program manager's guide. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- de Fossard, E. (1996). How to write a radio serial drama for social development: A script writer's manual. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Do, M. P., & Kincaid, D.L. (2001). Impact of the *Shabuj Chhaya* television drama in Bangladesh: Key findings. A working paper. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- El Shaffie, M., Brancich, C.D., El Gebaly, H., Kols, A., Boulay, M., Lewis, G., Saffitz, G., & Hess, R. (2000). Taking Quality Nationwide: Egypt's Gold Star Quality Family Planning Clinics. (Unpublished report). Cairo: Ministry of Health and Population. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Ferrara, M., Witte, K., & Jerato, K. (2002). *A Case Study of Journey of Life: A process evaluation of a radio serial drama*. (Unpublished report). Addis Ababa: Ethiopian National Office of Population. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Figueroa, M. E., Kincaid, D. L. Rani, M., & Lewis, G. (2002). Communication for social change: A framework for measuring the process and its outcomes. New York: The Rockefeller Foundation. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Figueroa, M.E., Bertrand, J.T., & Kincaid, D. L. (2002). Evaluating the Impact of Communication Programs. Summary of an Expert Meeting. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs. Chapel Hill, NC: The MEASURE Evaluation Project.
- Gabisirege S., & Babalola S. (2001). Perceptions à propos de la loi gacaca au Rwanda: résultats d'une étude multiméthode, Perceptions about the gacaca law in Rwanda: evidence from a multi-method study. *Special Publication*, No. 19. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Greenberg, R.H., Williams, J.R., Saffitz, G.B., Yonkler, J.B., & Rimón, II, J.G. (1996). How to Select and Work with an Advertising Agency, Handbook for Population and Health Communication Programs. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.

- Hasan, K. (2001). Shabuj Chhaya audience evaluation survey 2000 (Unpublished Report). Dhaka, Bangladesh: ORG-MARG QUEST, Social Research Division.
- Heerey, M., Merritt, A.P., & Kols, A.J., (2003). Improving the Quality of Care. Quality Improvement Projects from Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs. *Center Publication*. No. 101. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Heerey, M., Amoa, M., Chalk, G., Beisser, M., & Kols, A. (2003). Client-Provider Communication: Successful Approaches and Tools [CD-ROM]. Baltimore, Quality Associates, Inc. & Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Jabre B, Underwood C, & Goodsmith L. (1997). Arab Women Speak Out - Profiles of Self-Empowerment. *Special Publication*, No. 8. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Jato M.N., Simbakalia C., Tarasevich J.M., Awasum D.N., Kihinga C.N., & Ngirwamungu E. (1999). The impact of multimedia family planning promotion on the contraceptive behavior of women in Tanzania. *International Family Planning Perspectives*. 25(2):60-7.
- Kane, T.T., Gueye, M., Speizer, I., Pacque-Margolis, S., & Baron, D. (1998). The impact of family planning multimedia campaign in Bamako, Mali. *Studies in Family Planning*. 29(3):309-23.
- Kekovole, J., Kiragu, K., Muruli, L., & Josiah P. (1997). Reproductive Health Communication in Kenya: Results of a National Information, Communication, and Education Situation Survey. Country Report. *Field Report* No. 10, Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Kim, Y.M., Putjuk, F., Basuki, E., & Kols, A. (2003). Increasing Patient Participation in Reproductive Health Consultations: An Evaluation of "Smart Patient" Coaching in Indonesia. *Patient Education and Counseling*. In Press.
- Kim, Y.M., Figueroa, M.E., Martin, A., Silva, R., Acosta, S.F., Hurtado, M., Richardson, P., & Kols, A. (2002). Impact of supervision and self-assessment on doctor-patient communication in rural Mexico. *International Journal for Quality in Health Care*. 14(5):359-67.
- Kim, Y.M., Kols, A., Bonnin, C., Richardson, P., & Roter, D. (2001). Client communication behaviors with health care providers in Indonesia. *Patient Education and Counseling*. 45(1):59-68.
- Kim, Y.M., Kols, A., Nyakauru, R., Marangwanda, C., & Chibatamoto, P. (2001). Promoting sexual responsibility among young people in Zimbabwe. *International Family Planning Perspectives*. 27(1):11-19.
- Kim, Y.M., Kols, A., Mwargo, P., & Awasum, D. (2000). Differences in counseling men and women: family planning in Kenya. *Patient Education and Counseling*. 39(1):37-47.
- Kim, Y.M., Putjuk, F., Basuki, E., & Kols, A. (2000). Self-assessment and peer review: improving Indonesian service providers' communication with clients. *International Family Planning Perspectives*. 26(1):4-12.
- Kim, Y.M., Odallo, D., Thuo, M., & Kols, A. (1999). Client participation and provider communication in family planning counseling: transcript analysis in Kenya. *Health Communication*. 11(1):1-19.
- Kim, Y.M., Kols, A., & Mucheke, S. (1998). Informed choice and decision-making in family planning counseling in Kenya. *International Family Planning Perspectives*. 24(1):4-11 & 42.
- Kim, Y.M., & Marangwanda, C. (1997). Stimulating men's support for long-term contraception: a campaign in Zimbabwe. *Journal of Health Communication*. 2(4):271-97.
- Kim, Y.M., Marangwanda, C., & Kols, A. (1997). Quality of counseling of young clients in Zimbabwe. *East African Medical Journal*. 74(8):514-8.
- Kim, Y.M., Kols, A., Thuo, M., Mucheke, S., & Odallo, D. (1997). Client-Provider Communication in Family Planning: Assessing Audiotaped Consultations from Kenya. *Working Paper*. No. 5. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.

- Kim, Y.M., Marangwanda, C., & Kols, A. (1996). "Involving Men in Family Planning: The Zimbabwe Male Motivation and Family Planning Method Expansion Project, 1993-1994", *Field Report* No. 3, Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Kim, Y.M., Lettenmaier, C., Odallo, D., Thuo, M., & Khasiani, S. (1996). Haki Yako: a client provider information, education, and communication project in Kenya. *Field Report* No. 8. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Kim, Y.M., & Lettenmaier, C. (1995). Tools to Assess Family Planning Counseling: observation and interview. *Field Guide*. No. 1. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Kincaid, D. L., & Do, M. P. (2003). Causal attribution and cost-effectiveness of a national communication campaign: Family planning promotion in the Philippines. *A working paper*. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Kincaid, D.L. (2002). Drama, emotion, and cultural convergence. *Communication Theory*. 12(2):136-152.
- Kincaid, D.L. (2000). Social networks, ideation, and contraceptive behavior in Bangladesh: A longitudinal analysis. *Social Science & Medicine*. 50(2):215-31.
- Kincaid, D.L., Merritt, A.P., Nickerson, L., Buffington, S.D., de Castro, M.P., & de Castro, B.M. (1996). Impact of a mass media vasectomy promotion campaign in Brazil. *International Family Planning Perspectives*. 22(4):169-75.
- Kincaid, D.L., Yun, S.H., Piotrow, P.T., & Yaser, Y. (1992). Turkey's mass media family planning campaign. In T. E. Backer & E.M. Rogers (Eds.), *Organizational aspects of health communication campaigns: What works?* Newbury Park, CA: Sage.
- Kincaid, D.L. (2000). Mass media, ideation, and contraceptive behavior: a longitudinal analysis of contraceptive change in the Philippines. *Communication Research*. 27(6):723-63.
- Kincaid, D.L., Jara, J.R., Coleman, P.F., & Segura, F. (1988). Getting the Message: The Communication for Young People Project, *Special Study* No. 56. Washington, D.C.: USAID.
- Kiragu, K., Galiwango, M.K., Mulira, H.M., & Sekatawa, E. (1996). Promoting reproductive health in Uganda: evaluation of a national IEC program: the Uganda Family Planning Promotion Project and the Delivery of Improved Services for Health project. *Field Report* No. 7. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Kiragu, K., Chapman, S., & Lewis, G. (1996). The Nigeria Family Planning Facility Census. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Kiragu, K., Krenn, S., Kusemiju, B., Ajiboye, J.K., Chidi, I., & Kalu, O. (1996). Promoting family planning through mass media in Nigeria: campaigns using public service announcements and a national logo. *Field Report* No. 5. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Kiragu, K., Obwaka, E., Odallo, D., & Van Hulzen, C. (1996). Communicating about sex: adolescents and parents in Kenya. *AIDS/STD Health Promotion Exchange*. 3:11-3.
- Krenn, S., Kiragu, K., Odallo, D., & Sienché, C. (1998). Advocacy and Mass Media: Winning Combination for Kenyan Youth. *Communication Impact!* No. 2. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Kols, A.J., Sherman, J.E., & Piotrow, P.T. (1999). Ethical foundations of client-centered care in family planning. *Journal of Women's Health*. 8(3):303-12.
- Kornfield, R., Babalola, S., Awasum, D., & Quenum-Renaud, B. (2002). Living with AIDS in Rwanda: A Study in Three Provinces. *Special Publication*. No. 22, Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Lettenmaier, C., & Kiragu, K. (1999). Uganda Communication Campaigns Spur Integrated Health Programs. *Communication Impact!* No. 6. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.

- Lettenmaier, C., & Gallen, M. (1997). Why Counseling Counts! *Population Reports*. Series J. No. 36. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Liskin, L., & Berdy, M. (2000). The Care for Health Campaign: Making Family Planning a Household Norm in Russia. *Communication Impact!* No. 9. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- McKenzie, S., Rimon, J., & Saffitz, G. (1999). *New Directions: Proposal and Concept for a New NGO in the Philippines*. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- McPherson, J. (2001). *The Green Path Campaign for Family Planning and Health*. Final Report: PCS-supported Behavior Change Communication Program in Armenia (ENI-ARM-01). Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Murray-Johnson, L., Witte, K., Boulay, M., Figueroa, M.E., Storey, D., & Tweedie, I. (2002). Using health education theories to explain behavior change: A cross-country analysis. *International Quarterly of Community Health Education*, 20, 323-345.
- O'Sullivan, G.A., Yonkier, J.A., Morgan, W., & Merritt, A.P. (2003). *A Field Guide to Designing a Health Communication Strategy*. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Palmer, A. (2002). Reaching youth worldwide: Johns Hopkins Center for Communication Programs, 1995-2000. *Working Paper* No. 6. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Piotrow, P.T., & de Fossard, E. (2003). Entertainment-Education as a Public Health Intervention. *Entertainment-Education and Social Change: History, Research, and Practice*. Singhal, A., Cody, M., Rogers, E., & Sabido, M. (Eds). Mahway, NJ: M. Lawrence E. Baum, Inc.
- Piotrow, P.T., & Kincaid, D.L. (2001). Strategic Communication for International Health Programs. Chapter 14. *Public Communication Campaigns*. Third Edition. Edited by Ronald E. Rice and Charles K. Atkin. (Eds). Sage Publications, Inc.
- Piotrow, P.T., & Rimon, J.G. II (1999). Asia's population and family planning programmes: leaders in strategic communication. *Asia-Pacific Population Journal*. 14(4):73-90.
- Piotrow, P.T., Kincaid, D.L., Rimon, J.G. II, & Rinehart, W. (1997). *Health Communication: Lessons from Family Planning and Reproductive Health*. Westport, CT: Praeger.
- Piotrow, P.T. (1997). process and principals of strategic communication for health: update. *Special Publication*, No. 5. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Piotrow, P.T., Rimon, J.G. II, Winnard, K., Kincaid, D.L., Huntington, D., & Convisser, J. (1992). Changing men's attitudes and behavior: The Zimbabwe Male Motivation Project. *Studies in Family Planning*, 23(6), 365-375.
- Piotrow, P.T., Rimon, J.G. II, Winnard, K., Kincaid, D.L., Huntington, D., & Convisser, J. (1990). Mass media family planning promotion in three Nigerian cities. *Studies in Family Planning*. 21(5):265-74.
- Quenum-Renaud, B., & Awasum, D. (2000). Définir les Voies pour la Prévention du VIH/SIDA au Rwanda: Leçons Apprises sur les Aspects Comportementaux. *Special Publication*, No. 17. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Rimon, J.G. II, Lediard, M., MacLaren, L., Saffitz, G.B. (2003). *Koalisi Untuk Indonesia Sehat - KUIS (Healthy Indonesia Coalition) Redesign Team Report*, Population Communication Services. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Rimon, J.G. II. (November 2001). Behavior Change Communication in Public Health: Beyond Dialogue Moving Toward Convergence. Presented at the UN Roundtable on Development Communication, Managua, Nicaragua. Sponsored by UNFPA and the Panos Institute.

- Rimon, J.G. II, & de la Rosa, M. (1998). Philippines Communication Outreach Accelerates Family Planning Use in 1993-1996. *Communication Impact!* No. 3. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Rimon, J.G. II, Treiman, K.A., Kincaid, D.L., Silayan-Go, A., Camacho-Reyes, M.S., Abejuela, R.M., & Coleman, P.L. (1994). Promoting Sexual Responsibility in the Philippines through Music: An Enter-Educate Approach. *Occasional Paper Series*. No. 3. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Rinehart, W., Rudy, S., & Drennan, M. (1998). GATHER Guide to Counseling. *Population Reports*. Series J. No. 48. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Robey, B., Thomas, E., Baro, S., Kone, S., & Kpakpo, G. (1998). Men: Key Partners in Reproductive Health, A Report on the First Conference of French-Speaking African Countries on Men's Participation in Reproductive Health. *Special Publication*. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Robinson, W., & Lewis, G. (2002). Cost-effectiveness analysis of behavior change interventions: a proposed new approach and an application to Egypt. *Journal of Biosocial Science*. In Press.
- Saba, W., & Perez, A. (1999). Bolivia's Lilac Tent: A First in Health Promotion. *Communication Impact!* No. 5. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Saba, W. (1997). Forging Partnerships for Health in Latin America: Factors Influencing the Success of Interagencies Committees. Presentation at the American Public Health Association's 125th Annual Meeting, Indianapolis, IN.
- Snyder, L.B., Diop-Sidibé, N., & Badiane, L. A (2003). Meta-Analysis of the Impact of Family Planning Campaigns Conducted by the Johns Hopkins Bloomberg School of Public Health / Center for Communication Programs. Presented at the International Communication Association annual meeting, San Diego: May 2003.
- Sood, S. (2002). Audience Involvement and Entertainment-Education. *Communication Theory*. 12(2):153-172.
- Sood, S., Singhal, A., & Law, S. (1997). Analysis of educational themes and listeners' feedback to "Tinka Tinka Sukh," an entertainment-education soap opera in India. Paper presented at the 2nd International Conference on Entertainment-Education and Social Change, Athens, OH.
- Storey, D. & Jacobson, T. (2003). "Entertainment Education and Participation: Applying Habermas to a Case Study of a Population Program in Nepal", in Cody, M., Singhal, A., Sabido, M. & Rogers, E. (Eds.), *Entertainment-Education Worldwide: History, Research, and Practice*. Mahwah, NJ: Lawrence Erlbaum.
- Storey J.D. & Jacobson, T. (July 2002) Development Communication and Participation: Applying Habermas to a Case Study of Population Programs in Nepal. Presented at the 52nd Annual Conference of the International Communication Association, Seoul, Korea
- Storey, J.D., & Boulay, M. (2000). "Improving Family Planning Use and Quality of Service in Nepal through the Entertainment-Education Strategy," *Field Report* No. 12. Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Storey, J.D., Boulay, M., Karki, Y., Heckert, K., & Karmacharya, D.M. (1999). Impact of the integrated radio communication project in Nepal, 1994-1997. *Journal of Health Communication*. 4(4):271-94.
- Storey, J.D., & Sood, S. (1998). Distance Education Works. *Communication Impact!* No. 1. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Storey, J.D., Ilkhamov, A., & Saksvig, B. (1997). "Perceptions of Family Planning and Reproductive Health Issues: Focus Group Discussions in Kazakhstan, Turkmenistan, Kyrgyzstan, and Uzbekistan", *Field Report* No. 10, Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.

- Stratten, K., & Ainslie, R. (2003). A Field Guide for Organizations: How to Set Up a Hotline. *Field Guide* 101. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Thaddeus, S. (2000). Communicating Safe Motherhood in Morocco: The Family Planning/Maternal and Child Health Phase V Project. *Special Publication*, No. 14. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Thomas, E. (2002). Healthy Futures: Reducing Barriers to Primary School Completion for Kenyan Girls. *Special Publication*, No. 23. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Tweedie, I., Boulay, M., & Fiagbey, E. (2003). Stop AIDS Love Life in Ghana: “Shatters the Silence”. First phase leads to increase in protective behaviors nationally. *Communication Impact!* No. 15. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Tweedie, I., Boulay, M., Fiagbey, E., Banful, A., & Lokko, K. (2002). Ghana’s Stop AIDS Love Life Program Phase 1: Evaluation Report February 2000 - June 2001. Accra: Ghana Social Marketing Foundation. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Tweedie, I., Glover, E.K., Bannerman, A., Nerquaye-Tetteh, J., & Arkhurst, S. (1997). Context and content of condom and abstinence: Negotiation among youth in Ghana. Report on Qualitative Research. Ghana: Planned Parenthood Association of Ghana. University of Ghana, Legon/School of Performing Arts. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Underwood, C., & Jabre, B. (2003). “Arab Women Speak Out: Strategies for Self-Empowerment” in *Video Power: Images that Transform and Empower*. Shirley White. (Ed). Sage Publications, Inc.
- Underwood, C., & Jabre, B. (2001). AWSO Project Helps Arab Women Redirect Their Lives. *Communication Impact!* No. 13. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Underwood, C.R. (2000). Islamic precepts and family planning: The perceptions of Jordanian religious leaders and their constituents. *International Family Planning Perspectives*. 26(3):110-117 & 136.
- Valente, T.W. “Evaluating Communication Campaigns.” (2001). Chapter 6. *Public Communication Campaigns*. Third Edition. Ronald E. Rice and Charles K. Atkin. (Eds). Sage Publications, Inc.
- Valente, T.W., & Saba, W.P. (2001). Campaign Exposure and Interpersonal Communication as Factors in Contraceptive Use in Bolivia. *Journal of Health Communication*. 6(4):303-322.
- Valente, T.W., & Bharath, U. (1999). An evaluation of the use of drama to communicate HIV/AIDS information. *AIDS Education and Prevention*. 11(3):203-11.
- Valente, T.W., & Foreman, R.F. (1998). Integration and radiality: measuring the extent of an individual’s connectedness and reachability in a network. *Social Networks*. 20(1):89-105.
- Valente, T.W., Poppe, P.R., & Merritt, A.P. (1996). Mass-media-generated interpersonal communication as sources of information about family planning. *Journal of Health Communication*. 1(3):247-65.
- Valente, T.W., Paredes, P., & Poppe, P.R. (1998). Matching the message to the process: the relative ordering of knowledge, attitudes, and practices in behavior change research. *Human Communication Research*. 24(3):366-85.
- Valente, T.W., Saba, W.P., Merritt, A.P., Fryer, M.L., Forbes, T., Perez, A., & Ramiro Beltran, L. (1996). “Reproductive Health Is in Your Hands: Impact of the Bolivia National Reproductive Health Campaign”, *Field Report* No. 4, Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Valente, T.W., & Saba, W.P. (1998). Mass media and interpersonal influence in a reproductive health communication campaign in Bolivia. *Communication Research*. 25(1):96-124.

- van den Borne, F., Tweedie, I.A., & Morgan, W.B. (1996). "Family Planning and Reproductive Health in Zambia Today", *Field Report* No. 2, Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Whitney, E., Shahjahan, M., Kincaid, D.L., & de Fossard, E. (1999). Bangladesh Television Drama Promotes Integrated Services. *Communication Impact!* No. 7. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Yassa, A. (2003). Men in Jordan Get Involved in "Together for a Happy Family". *Communication Impact!* No. 14. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.
- Zabin L.S., & Kiragu, K. (1998). The health consequences of adolescent sexual and fertility behavior in sub-Saharan Africa. *Studies in Family Planning*. 29(2):210-32.
- Zaman, F., & Underwood, C. (2003). The gender guide for health communication programs. Center Publication No. 102. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.

Staff Acknowledgments

In recognition of the PCS leadership and current senior staff whose hard work, daily learning, and dedication to making a difference helped make the PCS4 project a success.

PCS SENIOR MANAGEMENT

PHYLLIS PIOTROW, *former Principal Investigator and founding Director, Center for Communication Programs*
JANE BERTRAND, *Principal Investigator and Director, Center for Communication Programs*
JOSE RIMON, *PCS Project Director and Deputy Director, Center for Communication Programs*
ALICE PAYNE MERRITT, *PCS Deputy Project Director (Africa and Latin America)*
GARY SAFFITZ, *PCS Deputy Project Director (Asia, Near East and Eastern Europe/Eurasia)*
PAUL BANKERD, *Finance*
ERIC REBBERT, *Human Resources*

PCS PARTNERS

BERENGERE DE NEGRI, CHAMBERLAIN DIALA, ELIZABETH THOMAS, LUCIA KRAMER, *Academy for Educational Development*; LISA HOWARD-GRABMAN, ANGELA BRASINGTON, *Save the Children*;
JOAN YONKLER, GAEL O'SULLIVAN, *Prospect Associates/American Institute for Research*;
FARIA ZAMAN, *Centre for Development and Population Activities*

REGIONAL DIRECTORS

SUSAN KRENN, *Africa*
EDSON WHITNEY, *Asia*
RON HESS, *Eastern Europe/Eurasia*
PATRICIA POPPE, *Latin America*

DIVISION DIRECTORS

MARIA ELENA FIGUEROA, *Research and Evaluation*
BENJAMIN LOZARE, *Training*
HUGH RIGBY, *Media/Materials Clearinghouse*

SENIOR TECHNICAL ADVISORS

PATRICK COLEMAN • ESTA DE FOSSARD • KIMM JAYNE • D. LAWRENCE KINCAID • JAMES WILLIAMS

SENIOR STAFF AND JHU FACULTY

ROBERT AINSLIE • KAREN ANGELICI • STELLA BABALOLA • KIRSTEN BOSE • MARC BOULAY •
JANE BROWN • WILLIAM CARTER • ARZUM CILOGLU • LINDA DONHAUSER •
FANNIE FONSECA-BECKER • WILLIAM GLASS • JENNIFER HALLYBURTON • MICHELLE HEEREY •
BUSHRA JABRE • YOUNG MI KIM • GARY LEWIS • JAYA NAIR • JUAN CARLOS NEGRETTE •
ANNE PALMER • PETER ROBERTS • WALTER SABA • JUAN SCHOEMAKER • CAROL SIENCHE •
SURUCHI SOOD • DOUGLAS STOREY • CAROL UNDERWOOD

COUNTRY OFFICES

Africa

ARAYA DEMISSIE, *Ethiopia*; IAN TWEEDIE, EMMANUEL FIAGBEY, *Ghana*; EMILY OBWAKA, *Kenya*; BOLA KUSEMIJU, *Nigeria*; DAVID AWASUM, *Rwanda*; CHEIKH FALL, *Senegal*

Asia

MOHAMMAD SHAHJAHAN, *Bangladesh*; V.S. CHANDRASHEKAR, *India*; FITRI PUTJUK, *Indonesia*;
DIANE SUMMERS, *Nepal*; JOSE MIGUEL DE LA ROSA, *Philippines*

Latin America

LUIS RAMIRO BELTRAN, *Regional*; ARIEL PEREZ, *Bolivia*; ROSA SAID, *Brazil*; PABLO PALACIOS, *Ecuador*;
ANTONIETA MARTIN, *Mexico*; OSCAR ORTIZ, *Nicaragua*; ROSA JAVALOYES, *Paraguay*

Near East, Europe and Eurasia

SOLIMAN FARAH, *Jordan*; LALI BEITRISHVILI, *Georgia*; ANNE SOCHAN, *Ukraine*;
JACKIE MCPHERSON, *Armenia*

IN MEMORIAM

In memory of those who contributed to PCS and who continue to be missed by their many colleagues and friends working in the field of strategic health communication.

PHILIPPE LANGLOIS • ROBERT FORSYTHE • RAPHAEL BARBATO

*Johns Hopkins Bloomberg School of Public Health
Center for Communication Programs
Population Communication Services
111 Market Place, Suite 310
Baltimore, Maryland 21202 USA
Tel: 410-659-6300 • Fax: 410-659-6266
E-mail: orders@jhuccp.org
Website: <http://www.jhuccp.org>*

